ADMINISTRATIVE INDICATORS & GUIDANCE
Review Year July 2011 through June 2012

The Guidance is provided as a resource to assist agencies with understanding Key Indicators. The Guidance is not intended to be, nor should be, considered as the ultimate defining resource. It should be, as inferred by its title, a GUIDANCE designed to assist. State and Federal standards including policies and procedures are the ultimate resources for establishing the requirements for an Indicator.

A1	Administrative Issues	Guidance
A1-01	For those for whom outlier status has been approved due to the need for enhanced staff support, the Board / Provider provides the additional support as outlined in the approved request	250-11-DD requires that residential service providers must retain staff schedules that document the increased level of supervision is being provided. Using the staffing schedule submitted by the provider and approved by SCDDSN, review the documentation that certifies that the enhanced staff support was provided (100% sample for the last quarter of the year in review) and compare with actual time sheets (showing hours actually worked) to determine if the enhanced staff support was provided. Source: MOA DDSN/HHS, 250-11DD (3/31/09)
A1-02	For those for whom outlier status has been approved due to the need for 1:1 staff support, the Board / Provider provides the additional support as outlined in the approved request	At the end of each shift that 1:1 Supervision was provided the direct care staff assigned to provide the 1:1 supervision must document that the 1:1 supervision was provided. Reviewers: Using the staff schedule submitted by the provider and approved by SCDDSN, review the documentation that certifies that the 1:1 supervision was provided (100% sample for the last quarter of the year in review) and compare with actual time sheets (showing hours actually worked) to determine if the 1:1 staff was provided. Source: MOA DDSN/DHHS, 250-11DD (3/31/09)
A1-03	The Board / Provider has a Human Rights Committee that is composed of a minimum of 5 members and includes representation from a family member of a person receiving services, a person representing those receiving services or a self-advocate nominated by the local self-advocacy group, and a representative of the community with expertise or a demonstrated interest in the care and treatment of persons (employees or former employees must not be appointed)	Review Board / Provider Policy regarding the Human Rights Committee. Review membership of the Board / Provider's Human Rights Committee to ensure that membership consists of the required persons and that none are employees or former employees. Membership should reflect cultural, racial, and disabilities diversity. Exceptions to the minimum and composition must be approved by the Associate State Director, Policy. Note: South Carolina Code Ann. 44-26-70 (Supp. 2007) requires that each DDSN Regional Center and DSN Board establish a Human Rights Committee. Contract service providers may either use the Human Rights Committee of the local DSN Board or establish their own Committee. Contract providers must have formal documentation of this relationship. *Apply the Admin. Indicators regarding Human Rights Committee and Risk Management to all Providers Source: South Carolina Code Ann. 44-26-70 (Supp. 2007) and 535-02-DD Supports CQL Basic Assurances Factor 1, Shared Values Factor 2

A1-04	The Human Rights Committee will provide review of Board / Provider practices to assure that consumer rights are protected	Review Board / Provider HRC policy to assure that its defined role and responsibilities are consistent with those set forth in DDSN policy 535-02-DD. Review Board / Provider HRC meeting minutes (100% sample) to determine if the HRC is fulfilling the role and responsibilities as set forth in its policy. Review Board/ Provider HRC meeting minutes/training records (100% sample) to determine if the HRC members have received training as described in DDSN policy 535-02-DD. Note: Effective 6/30/08 the person must be invited to attend HRC meetings when those meetings concern their care/treatment. *Apply the Admin. Indicators regarding Human Rights Committee and Risk Management to all Providers Source: 535-02-DD Supports CQL Basic Assurances Factor 1, Shared Values Factor 2
A1-05	The Board / Provider employ Service Coordination and/ or Early Intervention Staff who meet the minimum requirements for the position	Review all Service Coordinators hired during the review period, all SC Assistants, 25% or 5 experienced Service Coordinators (hired prior to review period) and all Service Coordinator Supervisors. Determine from personnel records if the minimum requirements for employment were met or if an exception to the requirement was granted by SCDDSN. Refer to SCDDSN Service Coordination Standards for educational and vocational requirements. Source: DDSN Service Coordination Standards Review all EI's hired during the review period, 25% or 5 experienced EI's (hired prior to review period) and all EI Supervisors. Determine from personnel records if the minimum requirements for employment were met or if an exception to the requirement was granted by SCDDSN. See Early Intervention Standards for educational, vocational and credentialing requirements. Source: EI Manual
A1-06	The Board / Provider employ Day Services and Residential staff who meet the minimum requirements for the position	Review personnel files for the last 5 currently employed staff in Day Services and Residential Services (if both services are offered, a total of 10 files will be reviewed). 1) Each program will designate a Program Director who meets the following minimal qualifications: a. Is at least twenty-one years old. b. Have a four-year, baccalaureate degree from an accredited college or university in the human services or related field and two year's experience in administration or supervision in the human services field or have a master's degree from an accredited college or university in the human services or related field and one year's experience in administration or supervision in the human services c. Have references from past employment. 2) Each program will employ direct care staff members who meet the following qualifications: a. Is at least eighteen years old. b. Have a valid high school diploma or its certified equivalent. c. Have references from past employment if applicable.

		3) Staff must meet requirements for criminal background checks. Checks should be done in accordance with South Carolina Code Annotated §44-7-2910 (Supp 2007), No support provider may be employed who has been convicted, pled guilty or nolo contendere to: 1. Abuse, neglect or mistreatment of a consumer in any health care setting; 2. An "Offense Against the Person" as provided for in Chapter 3, Title16; 3. An "Offense Against Morality or Decency" as provided for in Chapter 15, Title 16; 4. Contributing to the delinquency of a minor as provided for in Section 16-17-490 5. The common law offense of assault and battery of a high and aggravated nature; 6. Criminal domestic violence, as defined in Section 16-25-20 7. A felony drug-related offense under the laws of this state; and 8. A person who has been convicted of a criminal offense similar in nature to a crime previously enumerated when the crime was committed in another jurisdiction or under federal law; has a substantiated history of child abuse and/or neglect and/or convictions of those crimes listed in SC Code 20-7-1642 and/or is listed on the SC Sex Offender Registry 4) Staff must pass an initial physical exam prior to working in the program. Pass = No documentation in the physical exam report of conditions present that would jeopardize health and safety of people receiving services or staff's ability to perform required duties. 5) Staff must pass initial tuberculosis screening prior to working in the program and annually thereafter. Pass = no evidence of communicable disease. Meet requirements of 603-06-DD Source: Residential and Day Services Standards
A1-07	Service Coordination and Early Intervention staff receive training as required	Review personnel files to determine if training occurred as required. Review all Service Coordinators hired during the review period, all SC Assistants, 25% or 5 experienced Service Coordinators (hired prior to review period) and all Service Coordinator Supervisors. Refer to Service Coordination Standards and SCDDSN Policy 534-02-DD regarding staff training related to abuse, neglect and exploitation and SCDDSN Policy 567-01-DD regarding HIPPA Training. Service Coordination staff must be provided training and must demonstrate competency in the following topic areas: SCDDSN Service Coordination Standards (including but not limited to, Assessment, Care Planning, Referral and Linkage, Monitoring or Follow-up and reportable and non-reportable activities including service documentation), SCDDSN policies and procedures applicable to Service Coordination, Rights, Local, State, and Community Resources, Access to and use of CDSS/STS, Nature of MR/RD, Autism, traumatic brain injury, spinal cord injury and similar disability (as appropriate), Abuse and Neglect, and Confidentiality. After the first year of employment, all Service Coordination staff must receive a minimum of 12 hours of training annually on topics related to the provision of Service Coordination services and must include training on Abuse and Neglect and Confidentiality. Source: DDSN Service Coordination Standards Supports CQL Shared Values Factors 8 & 10 Review personnel files to determine if training occurred as required. Review all EIs hired during the review period, 25% or 5 experienced EI's (hired prior to review period) and all EI Supervisors to ensure that they received initial and ongoing training as documented in their personnel file or records

		maintained by the EI Supervisor. Staff must comply with SCDDSN Policy 534-02-DD regarding staff training related to abuse, neglect and exploitation. Source: EI Manual Supports CQL Shared Values Factors 8 & 10
A1-08	Day Services and Residential Services staff receive training as required	Review personnel files for the last 5 currently employed staff in Day Services and Residential Services (if both services are offered, a total of 10 files will be reviewed). Staff must be trained and be deemed competent in accordance with Department Directive 567-01-DD. There will be a staff development / in-service education program operable in each provider agency which requires all staff to participate in in-service education programs and staff development opportunities. From 567-01-DD: Staff must periodically be required to demonstrate continuing competency on the most critical information and skills taught in the curriculum. Providers have wide latitude in designing the format of such rechecks. Encouraging staff commitment to continuing personal and professional development will expand the capacity to provide quality service and supports. Staff should routinely be exposed to information regarding training resources and opportunities. Supervisors should be working with staff to identify annual personal and professional goals. At a minimum, the provider must document initial employee training. Annually, the provider must document training in the areas of Prevention of Abuse, Neglect and Exploitation, Consumer Confidentiality, Disaster Preparedness, CPR, and an approved behavior supports/ crisis management curriculum, plus a minimum of 10 hours of additional training. Source: Residential and Day Services Standards
A1-09	Board / Provider implements a risk management and quality assurance program consistent with 100-26-DD and 100-28-DD	Board / Provider demonstrates implementation of risk management/quality assurance principles by: • designated risk manager and a risk management committee; • written policies/procedures used to collect, analyze and act on risk data • documentation of remediation taken • correlating risk management activities with quality assurance activities. *Apply the Admin. Indicators regarding Human Rights Committee and Risk Management to all Providers Source: 100-26-DD and 100-28-DD Supports CQL Basic Assurances Factors 6 & 10
A1-10	Board / Provider follows SCDDSN procedures regarding preventing, reporting and responding to abuse / neglect / exploitation as outlined in 534-02-DD	Board / Provider demonstrates usage of the most current abuse/neglect/exploitation county profile data report to: • evaluate provider specific trends over time • evaluate/explain why the provider specific ANE rate is over, under or at the statewide average • demonstrate systemic actions to prevent future abuse/ neglect/exploitation Source: 534-02-DD Supports CQL Basic Assurances Factors 4, 6, & 10

A1-11	Board / Provider follows SCDDSN procedures regarding preventing, reporting and responding to critical incidents as outlined in 100-09-DD	Board / Provider demonstrates usage of the most current critical incident county profile data report to: • evaluate provider specific trends over time • evaluate/explain why the provider specific CI rate is over, under or at the statewide average • demonstrate systemic actions, as applicable, to prevent future incidents Source: 100-09-DD Supports CQL Basic Assurances Factors 4, 5, 6, & 10
A1-12	Board / Provider follows SCDDSN procedures regarding death or impending death as outlined in 505-02-DD	Board / Provider demonstrates usage of the most current death county profile data report to: • evaluate provider specific trends over time • evaluate/explain why the provider specific death rate is over, under or at the statewide average • demonstrate systemic actions, as applicable, to prevent future occurrences Source: 505-02-DD Supports CQL Basic Assurances Factor 10 and Shared Values Factor 10
A1-13	The Board / Provider follows SCDDSN procedures regarding Medication Error/ Event Reporting, as outlined in 100-29-DD	Determine if the Board / Provider has developed an internal database to record, track, analyze, and trend medication errors or events associated with the administration of medication errors. Proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including medication technician certification), changes in procedure, securing additional technical assistance from a consulting pharmacist or other medical professional, and improving levels of supervision. If medication errors have been recorded, but not analyzed, the standard has not been met. Source: 100-29-DD Supports CQL Basic Assurances Factor 5
A1-14	Upper level management staff of the Board / Provider conduct quarterly unannounced visits to all residential settings to assure sufficient staffing and supervision are provided. SLP II should include visits to all apartments	When a residential setting does not utilize a shift model for staffing (e.g. CTH I and SLPI) visits need only to be conducted quarterly. Managers should not visit homes they supervise, but should visit homes managed by their peers. Senior management may visit any/all of the homes. Documentation of the visit must include the date and time of the visit, the names of the staff/caregivers and residents present, notation of any concerns and actions taken in response to noted concerns. Please note: It is not necessary to visit individual SLP II apartments during 3rd shift, although 3rd shift checks to the complex/staff review are still required. *Quarterly = 4 times per year with no more that 4 months between visits. Source: Contract…Capitated Model Article III Supports CQL Basic Assurances Factor 10

A1-15	Board / Provider keep service recipients' records secure and information confidential	Determine if records are maintained in secure locations. Look for evidence that confidential information is kept confidential. Consider the following: • Are any records in public areas or in areas that are not secure including lying on desks in empty offices, etc? • Is personal information in conspicuous locations or posted in common areas? • Is information about one person found in another person's file? (Cite only if two or more occurrences) • Are records/information provided or released without consent including by the phone? • Are computers and fax machines in easily accessible public areas with incoming/outgoing information left on/around the machine? • Are staff heard discussing information about clients in restrooms, hallways, etc. in a manner that clearly identifies the person about whom they are speaking? Source: 167-06-DD
A1-16	The provider agency of HASCI Division Rehabilitation Supports (RS) maintains required administrative records for the RS Program *HASCI Only	Review agency administrative records to confirm presence of the following: • Documentation of qualifications of RS Staff, including RS Coordinator, RS Specialist and Clinical Professional providing tiered clinical supervision of the RS Program if the RS Coordinator is not a "Licensed or Master's level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)* • Documentation of Pre-Service Training of RS Specialists to include date, amount of time, those in attendance, name of trainer(s), and topic(s) covered • Documentation of In-service Training of RS Specialists to include date, amount of time, those in attendance, name of trainer(s), and topic(s) covered • Documentation of at least monthly Staff Meetings (individual or group) conducted by the RS Coordinator with RS Specialist(s) to include date, those in attendance, person(s) discussed, forms reviewed and signed, other issues addressed, and any recommendations made by the RS Coordinator • If the RS Coordinator is not a "Licensed or Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)*, documentation of at least monthly meetings of RS Coordinator with a qualified Clinical Professional to include date, persons/staff discussed, forms reviewed and co-signed, other issues addressed, and any recommendations made by the Clinical Professional • Documentation of any individual case consultations provided by the RS Coordinator or Clinical Professional if not in a person's RS Record, to include name of consumer, date, those in attendance, issues addressed, and any recommendations made • Waiting list for Rehabilitation Supports to include name of consumers and date added to/removed from waiting list Source: Rehabilitation Supports Manual
A1-17	Board / Provider conducts all residential admissions / discharges in accordance with 502-01-DD	Review all "Community Residential Admissions/Discharge Reports" submitted to DDSN. Review relevant supporting documentation to assure all of the admissions / discharge criteria stipulated in 502-01-DD were met. Compare "Community Residential Admissions / Discharge Reports" against relevant CDSS/STS data to assure actual admissions / discharges and transfers do not occur prior to DDSN approval (District Office and Central Office). Also, verify that the home is properly licensed for the number of people intended to live there, including the new admission, on the admission date. Source: 502-01-DD

A1-18	Annually, employees are made aware of the False Claims Recovery Act, that the Federal government can impose a penalty for false claims, that abuse of the Medicaid Program can be reported and that reporters are covered by Whistleblowers' laws	Review the annual statement that all employees sign concerning fraud, abuse, neglect, and exploitation of consumers to determine if it also contains a statement that (1) the employee is aware of the False Claims Act and that the Federal Government can impose a penalty on any person who submits a false claim to the federal government that he/she knows or should know is false; (2) they are aware that they can report abuse of the Medicaid program; and, (3) they are protected by "Whistleblower Laws." Source: Contract for … Capitated Model and Source: Contract for … Non-Capitated Model
A1-19	Service Coordination providers must have a system that allows access to assistance 24 hours daily, 7 days a week	Test the system by making calls before/after normal business hours.
A1-20	The Residential Habilitation provider must have procedures that specify the actions to be taken to assure that <u>within 24 hours</u> following a visit to a physician, Certified Nurse Practitioner (CNP), or Physician's Assistant (PA all ordered treatments will be provided	Verify that a system is in place that specifies actions to be taken to assure that within 24 hours following a visit to a physician, CNP, or PA, all ordered treatments will be provided. Source: Residential Habilitation Standard RH 5.0 Supports CQL Basic Assurances - A3.

A2	Fiscal Issues	Guidance
A2-01	The Governing Board approves the annual budget and Comprehensive Financial Reports are presented at least quarterly to the Governing Board with a comparison to the approved budget	Review Governing Board Minutes for evidence that the Board approves the annual budget and reviews Financial Reports at least on a quarterly basis. Source: Contract for …Capitated Model and Contract for Non-Capitated Model Supports CQL Basic Assurances Factor 10
A2-02	Annual Audit Report is presented to Governing Board once a year and includes the written management letter *Board Providers Only	Review Governing Board minutes to determine if the final annual audit report and any management letter comments are presented by the external auditor or CPA to the Governing Board. Source: 275-04-DD Supports CQL Basic Assurances Factor 10
A2-03	The person's financial responsibility is made known to them by the Board / Provider *All Residential Providers	Determine that a Statement of Financial Rights exists and was completed when the person was admitted to the residential program. This form should be signed by the person or his/her parent, guardian, or responsible party.

GENERAL AGENCY INDICATORS & GUIDANCE
Review Year July 2011 through June 2012

The Guidance is provided as a resource to assist agencies with understanding Key Indicators. The Guidance is not intended to be, nor should be, considered as the ultimate defining resource. It should be, as inferred by its title, a GUIDANCE designed to assist. State and Federal standards including policies and procedures are the ultimate resources for establishing the requirements for an Indicator.

G1	Service Coordination Support Plan	Guidance
G1-01 R	**The Plan is developed by the Service Coordinator within 365 days**	**Review current Plan. A current Plan must be present. A current Plan is defined as one completed within the last 365 days. When there is a leap year, the plan date would be calculated accordingly to ensure the plan is developed and signed within 365 days.** **Except for those transferring from an ICF/MR, Plans must be entered into the Consumer Data and Support System (CDSS) using the Consumer Assessment and Planning (CAP) module unless otherwise approved by the SCDDSN Director of Service Coordination. The Plan implementation date is the date a plan is completed in the CAP module of CDSS.** **For those receiving Level 1 Service Coordination, a plan must be completed on CDSS:** • **By the 45th calendar day following the determination of eligibility for SCDDSN services** • **Within 365 days of the last plan** • **By the 45th day of being transferred from Level II Service Coordination** • **By the 45th day of being transferred from Early Intervention** • **Before Waiver Services are authorized/provided.** **Source: Support Plan Instructions and the Service Coordination Standards.**
G1-02	Needs in the Plan are justified by formal or informal assessment information in the record	Review the Service Coordination record to determine if formal or informal assessment information is available to justify the "need" noted on the Plan for which interventions are being implemented. The assessment information (formal or informal) must be current and accurate. Formal and/or informal assessments may include information provided by the person and/or his/her caregivers about the person's current situation, medical status, school records or other formalized assessment tools. At the time of annual planning, the *SCDDSN Service Coordination Annual Assessment* will be used to identify needs and justify services/interventions reflected in the Support Plan. The *SCDDSN Service Coordination Annual Assessment* (SCAA) must be completed on the CAP module of CDSS unless otherwise approved by SCDDSN. Information from providers currently providing services should be considered in planning. The record should reflect attempts to secure information from all current service providers. Attempts should be made in sufficient time prior to planning so that information can be secured. If the person is enrolled in the Waiver, then formal or informal assessments and recommendations for all Waiver services will be present. Needs assessment during the course of the year *outside* of annual planning will be documented in the service notes. Source: "Guidelines on How to Complete the SCDDSN Annual Service Coordination Assessment", Support Plan Instructions, Service Coordination Standards, Waiver Manuals pertaining to needs assessment.

G1-03	Services/ Interventions are appropriate to meet assessed needs	Interventions are identified to address assessed "needs". Interventions must have a logical connection to the need. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"* for defined resources and the Service Coordination Standards glossaries. Also, reference Service Coordination Standards and Waiver Manuals.
G1-04	The Plan identifies appropriate funding sources for services/interventions	Appropriate funding sources are identified for every service/intervention. Review the person's "current resources" identified in the SCDDSN Service Coordination Annual Assessment (or the service notes when needs assessment occurs outside of planning and resources have changed from those noted on the Plan) to determine what resources the person has. Compare the person's resources to the services/interventions noted on the Plan to determine if the appropriate funding source is listed for the service/intervention to be/being provided. Source: *"Guidelines for Completion of the SCDDSN Service Coordination Annual Assessment"* for defined resources and the Service Coordination Standards glossaries. Also, reference Service Coordination Standards and Waiver Manuals.
G1-05	The Plan is amended / updated as needed	Review all plans and service notes in effect during the review period to determine if: a. updates are made when new service needs or interventions are identified, b. there have been significant changes in the person's life, c. a service is determined to not be effective, d. a need/s has/have been met, e. the person is not satisfied. When any part of the "Needs/Interventions" section (Section D) of the plan is no longer current, an amendment/update must be completed using the CAP module of CDSS. It is acceptable to have a brief service note provided the change/update is explained in detail on the "needs change" form printed from the CAP module of CDSS for the file. For new needs identified during the course of the year, needs assessment and identification of the need will be in the service notes and, if applicable, a new "needs/interventions" page will be added to the plan using the CAP module of CDSS. Plan must be current at all times. Source: Support Plan Instructions, Service Coordination Standards and Waiver Manuals. Supports CQL Shared Values Factor 8
G1-06	The Plan is reviewed at least every 6 months	1. Review the Plan to determine if all needs and interventions were reviewed as often as needed, but at least every 6 months. 2. Ensure that needs and interventions were implemented as prescribed in the Plan. Six Month reviews are completed on the CAP module of CDSS. Monitoring/review forms on CAP include all of the necessary components of monitoring Refer to Service Coordination Standards and Support Plan Instructions

G2	Service Coordination	Guidance
G2-01 W	Contact occurs as required: a) Face-to-face contacts occur every 6 months b) Every other month (bi-monthly), at least one contact (as defined by SC Standards) is made	Beginning 7/1/11, review to determine that: a) Face-to-face visits occur every 6 months and are with the person receiving services and/or legal guardian. b) At least one contact is made every other month (bi-monthly). A contact is defined as any of the following: • A face-to-face encounter for the purpose of performing a core function. • A telephone call, letter or email when a face-to-face contact is not required or is not possible for the purpose of performing a core function Source: Service Coordination Standards
G2-02 W	If determined eligible for DDSN services after 9/2001, an eligibility correspondence from the CAT is on file	Review the Service Coordination record for SCDDSN Eligibility Determination Correspondence (correspondence from the Consumer Assessment Team regarding the person's eligibility. If prior to 9/01, information may not be available from the Consumer Assessment Team; therefore, absence of eligibility information prior to 9/01 should not be held against the provider. Source: Service Coordination Standards
G2-03	A valid Service Agreement is present and signed as appropriate	A valid Service Agreement (review most recently completed Service Agreement to assure that it is dated and signed.) For children and for adult's adjudicated incompetent, the current legal guardian (if applicable) must sign the form. For those 18 years and older or those with a name change, a new Service Agreement should be signed by the person. The most current Service Agreement that is signed and dated by the appropriate party must be filed in the primary case record. Score "Not Met" if there is not a Service Agreement in the primary case record and/or it is not signed and dated by the appropriate party. If a person is unable to sign but can make their "mark", the mark must be witnessed. If a person is unable to sign or make their mark on the Service Agreement, there will be an explanation on the form and supporting documentation in the file. Source: Service Coordination Standards
G2-04	Upon notification of an identified health care need, the Service Coordinator has provided information for, offered choice of and monitored a person's access to health care services/providers (inclusive of primary health care provider / physician) when health care needs are identified	As needs are identified for health care, the person's options for health care and choice of health care providers were discussed to make sure the person has accessed health care to address needs. The record clearly reflects the person/legal guardian's (if legal guardian is applicable)decision not to have a primary physician, or if the record reflects the person has a primary physician and is satisfied with his/her physician, the record does not have to show that the Service Coordinator provided information for and offered choice of primary healthcare services/providers. All persons must have a choice of physician/specialist for healthcare needs even if the Board / Provider contracts with a physician unless there are no other physicians in the area. Medical records/reports can serve as a form of assessment provided the Service Coordinator has addressed all recommendations from those reports and by providing information (understanding of options of care and choice of providers) and monitoring access of healthcare services as a result of the recommendations. NOTE: Where there is no reasonable choice available due to the presence of only one qualifying physician within a reasonable distance, this item should be scored "Met" reflecting compliance provided that this is documented in the record. Source: Service Coordination Standards Supports CQL Basic Assurances Factors 5 & 9, Shared Values Factor 3

G2-05	The person/legal guardian (if applicable) will receive information on abuse and neglect annually	Check the record for documentation that information was provided to person/legal guardian. This may be found in service notes or as a form letter in the record. Information must define what abuse and neglect is and how to report. Source: Service Coordination Standards; CQL Basic Assurances 1, 2, 4,10
G2-06	Beginning 3/1/2011, at the time of annual planning, all children enrolled in the MR/RD or CS Waiver receiving CPCA services must have a newly completed physician's order (Physician's Information Form – MSP Form 1), assessment (CPCA Assessment – MSP Form 2), and authorization (MSP – Form 3)	See MSP forms/attachments in the miscellaneous Chapters of the MR/RD and CS Waiver Manuals.
G2-07	If a child is assessed to need over 10 hours of Children's PCA services per week, DDSN prior authorization is obtained	Review file for an email correspondence giving approval of requested units of CPCA services. If service units were not approved prior to initiation of the service, or prior to the completion of the annual plan, there must be a correspondence present allowing flexibility with approval.
G2-08	If a child receives CPCA services, the Service Needs Requirement and, unless otherwise specified, a Functional deficit exists (check only for those receiving 10 hours or less of CPCA services)	Refer to CPCA services section of the Waiver Manual (Miscellaneous chapter), page one, for guidance to determine if the child meets the "Special Needs Requirement" and has one of the four allowable "Functional Deficits". Look for The Physician's Information Form – it will be present and indicate if a doctor agrees CPCA services is needed to meet the Special Needs Requirement (section II. Of the form). Look for the CPCA Assessment – it gives information to determine if at least one functional deficit is present.

G3	Day Services *With the exception of Employment–Individual (See G4 Indicators)	A"DDSN Day Service" includes Career Preparation, Employment Services through a Mobile Work Crew or Enclave, Community Service, Day Activity, or Support Center. *Employment Services through Individual Community Employment is not included. Indicator Guidance with Observation Guidelines
G3-01	After acceptance into service but prior to the first day of attendance into a DDSN Day Service, a preliminary plan must be developed that outlines the care, and supervision to be provided	Plan must include essential information to ensure appropriate services and supports are in place to assure health, safety, supervision and rights protection. Applies only to those admitted to the Day Service within 12 months prior to review. For all others, this Indicator will be N/A. Source: Day Services Standards
G3-02	On the first day of attendance in a DDSN Day Service, the preliminary plan must be implemented **OBSERVATION:** The interventions in the plan are implemented	Preliminary plan is to be implemented on the day of admission. When assessments are completed and training needs/priorities have been identified, the plan will be completed and will replace the preliminary plan. Applies only to those admitted to the Day Service within 30 days prior to the review. For all others, this Indicator will be N/A. Source: Day Services Standards
G3-03	Within thirty (30) calendar days of the first day of attendance into a DDSN Day Service and annually thereafter, an assessment will be completed	At a minimum, assessments must be completed every 12 months. Source: Day Services Standards
G3-04	The assessment identifies the: (1) abilities / strengths, (2) interests / preferences and (3) needs of the person	The assessment identifies the (1) abilities / strengths, (2) interests / preferences and (3) needs of the person in the following areas: **Career Preparation** • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation • Mobility and Transportation • Community Safety • Money Management • Pre-Employment • Job Search **Employment (Mobile Work Crew/Enclave)** • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation

		• Mobility and Transportation • Community Safety • Money Management • Pre-Employment • Job Search **Community Service** • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation • Mobility and Transportation • Community Safety • Money Management **Day Activity** • Self-Advocacy/Self Determination • Self-Esteem • Coping Skills • Personal Responsibility • Personal Health and Hygiene • Socialization • Community Participation • Mobility and Transportation • Community Safety • Money Management **Support Center** • non-medical care, • the supervision, • assistance and • interests / preferences of the person. Source: Day Services Standards
G3-05	Based on the results of the assessment, within thirty (30) calendar days of the first day of attendance and annually thereafter, a plan is developed with participation from the individual and/or his/her legal guardian	At a minimum, the plan must be completed every 12 months. Source: Day Services Standards

G3-06	The plan must include: a) A description of the interventions to be provided including time limited and measurable goals/objectives when the person participates in **Day Activity**, **Employment Services**, **Community Services**, and/or **Career Preparation** b) or, a description of the care and assistance to be provided when the person participates in **Support Center**	a) A description of the interventions to be provided including time limited and measurable goals/objectives when the person participates in **Day Activity, Employment Services, Community Services,** and/or **Career Preparation**. Note: Interventions must support the authorized service as defined in these standards. b) A description of the care and assistance to be provided when the person participates in **Support Center**. Source: Day Services Standards
G3-07	The plan must include a description of the type and frequency of supervision to be provided	• In accordance with Department Directive 510-01-DD, services provided shall include the provision of any interventions and supervision needed by the person which includes dining/eating. • The interventions to be provided must be based on assessed needs. • Supervision must encompass any time outside of the actual unit time when the person is present and supervision is needed. Source: Day Services Standards
G3-08	For **Support Center** persons, the plan must include a description of the kinds of activities in which the person is interested or prefers to participate	Goals and objectives are not required for **Support Center** persons. Note: This Indicator is N/A for all other Day Services. Source: Day Services Standards
G3-09	The interventions in the plan must support the provision of the DDSN Day Service(s) as defined in the standards	The interventions in the plan must support the provision of the DDSN Day Service(s) as defined in the standards: **Career Preparation** is aimed at preparing persons for careers through exposure to and experience with various careers and through teaching such concepts as compliance, attendance, task completion, problem solving, safety, self determination, and self-advocacy. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the person's service plan and are directed to habilitative rather than explicit employment objectives. Services will be provided in facilities licensed by the state. DDSN Day activities that originate from a facility licensed by the state will be provided and billed as DDSN Day. On site attendance at the licensed facility is not required to receive services that originate from the facility. **Employment Services** consist of intensive, on-going supports that enable persons for whom competitive employment at or above minimum wage is unlikely absent the provision of supports and who, because of their disabilities, need supports to perform in a regular work setting. Employment Services may include services to assist the person to locate a job or develop a job on behalf of the person. Employment services are conducted in a

		variety of settings, particularly work sites where persons without disabilities are employed and include activities such as supervision and training needed to sustain paid work. Employment Services may be provided in group settings, such as mobile work crews or enclaves, or in community-based individual job placements. **Community Service** is aimed at developing one's awareness of, interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital. Services will be provided in facilities licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Community Service. On site attendance at the licensed facility is not required to receive services that originate from the facility. **Day Activity Services** are supports and services provided in therapeutic settings to enable persons to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Day Activity Service. On site attendance at the licensed facility is not required to receive services that originate from the facility. **Support Center Service** includes non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the person's home to people who because of their disability are unable to care for and supervise themselves. Services provided are necessary to prevent institutionalization and maintain the persons' health and safety. The care, supervision and assistance will be provided in accordance with a plan of care. An array of non -habilitative activities and opportunities for socialization will be offered throughout the day but not as therapeutic goals. **All Services**: Transportation will be provided from the person's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the person's habilitation site to their residence when the service start time is after 12:00 Noon. Source: Day Services Standards

G3-10	As soon as the plan is developed, it must be implemented
	
	OBSERVATION
		• The interventions in the plan must support the provisions of the Day Service as defined in the standards.
		
		• The interventions in the plan are implemented as specified in the plan. This includes:
		  ○ The type and frequency of supervision as well as,
		  ○ Specific training.
		
		Source: Day Services Standards

G3-11	Data must be collected as specified in the plan and must be sufficient to support the implementation of the plan for each unit of service reported	For each unit of service provided: • Documentation must be present to show the service was provided on the day the service was reported. • Additionally, for training objectives, the data documenting the response to and/or outcome of training must be sufficient to measure the progress. Source: Day Services Standards
G3-12	At least monthly, the plan is monitored by the Program Director or his/her designee to determine its effectiveness	• The Program Director's or designee's signature on the Monthly Data Recording Sheet signifies that the training intervention(s) in the plan have been monitored. • An evaluation of progress for each training intervention must be noted. Source: Day Services Standards
G3-13	The plan is amended when significant changes to the plan are necessary	Significant changes may include, but are not limited to: • Interventions are not appropriate, • Interventions are not supporting progress, and/or • The person's life situation has changed. Source: Day Services Standards

G4	Employment-Individual Placement	Guidance
G4-01	A comprehensive vocational service assessment that is appropriate for the authorized service is completed within 30 calendar days of admission/enrollment in the service	• A comprehensive service assessment will be appropriate for the authorized service. • The service assessment will be completed within 30 calendar days of acceptance into the service. • Annual assessment is not required. Source: Employment Services Standards
G4-02	An individual plan of employment is developed within 30 calendar days of admission/enrollment	• The individual plan of employment must contain the same information as the Individual Plan of Supported Employment (IPSE) • The record must reflect that the individual participated in decisions regarding his/her services as evidenced by required signatures in the individual plan of employment as in Section 4, Terms and Conditions of the IPSE. • The individual plan of employment is not an annual plan. Source: Employment Services Standards
G4-03	The record will contain notations that show evidence of monitoring and evaluation of progress	• Documentation, monitoring and evaluating of activities is current and updated. • Documentation includes the date of the activity, the number of hours for each activity and a detailed description of the activity. Source: Employment Services Standards
G4-04	Individualized, on-the-job instruction and needed and wanted supports are being provided in a nonintrusive method	• A record of an employment training plan including interventions (training objectives) and evaluations is documented to support individualized instruction on the job Source: Employment Services Standards
G4-05	Long-term support plans are identified in the individual plan of employment and contact with the individual is maintained monthly for a minimum of 6 months	• Identify needs, preferences, options and long term support plans. The employment specialist must maintain contact monthly for at least 6 months to determine the long term plan is sufficient and ensure job retention and stability. Source: Employment Services Standards
G4-06	An exit interview is conducted when a individual no longer needs the service of the Employment Specialist	• At a determined point when the consumer becomes stabilized in his/her employment position and long term support needs have been identified or the consumer is terminated voluntarily or involuntarily from services, an exit interview must be conducted prior to termination of Employment Services/Individual Placement. Source: Employment Services Standards

G5	HASCI Division Rehabilitation Supports	Guidance
G5-01	The participant's RS Record contains a valid Medical Necessity Statement (MNS)	Review RS record to confirm presence of a Medical Necessity Statement *(RS Form 2)* signed prior to initiation of RS during review period. For ongoing participants, there must be a MNS signed no more than 365 calendar days after previous MNS was signed. When RS were not received for 45 consecutive, there must be a new MNS signed prior to reinstatement of RS. In all instances, the MNS must be signed by a "Licensed Practitioner of the Healing Arts" (LPHA) as defined by SCDHHS (RS Manual – Appendix A). Source: Rehabilitation Supports Manual
G5-02	The participant's RS Record documents a valid comprehensive assessment of the consumer's needs and strengths to guide development/update of a support plan	Review RS Record to confirm presence of a Rehabilitation Supports Assessment *(RS Form 3)* completed no later than 20 business days after date the RS slot was awarded and prior to development of initial IPOC and initiation of RS during review period. For ongoing participants, there must be an RS Assessment update completed within 365 calendar days of previous one. Source: Rehabilitation Supports Manual
G5-03	The participant's RS Record contains a valid Individual Plan of Care (IPOC)	Review RS Record to confirm presence of a Rehabilitation Supports Individual Plan of Care *(RS Form 4)* completed no later than 20 business days after the RS slot was awarded, within 45 calendar days of date MNS was signed, and prior to initiation of RS during review period. For ongoing participants, there must be an update of the IPOC completed within at least 365 calendar days of date of previous IPOC. If RS were not received for 45 consecutive days, the IPOC must be updated within 45 calendar days of the date a new MNS was signed. The IPOC and each subsequent amendment (*RS Form 5* attached to initial or updated *RS Form 4*) must be signed by the participant, parent or guardian if necessary, and RS Coordinator. If the RS Coordinator is not a "Licensed or Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)* the forms must be co-signed by a Clinical Professional. Source: Rehabilitation Supports Manual
G5-04	The participant's RS Record contains 90 Day Progress Reviews of the Individual Plan of Care	Review RS Record to confirm presence of a 90 Day Progress Review of the IPOC conducted at least 90 calendar days from the signature date of the initial IPOC or annual update (regardless of amendments) and at least every 90 calendar days thereafter (regardless of amendments). Latest dates for completing 90 Day progress Reviews must be documented as part of the IPOC *(RS Form 4, Page 2)*, including date, progress of participant, effectiveness of methods/frequency, participants continued need for RS, and comments/recommendations. Each 90 Day Progress Review must be signed by the RS Coordinator. If the RS Coordinator is not a "Licensed of Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)*, it must be co-signed by a Clinical Professional. Source: Rehabilitation Supports Manual
G5-05	The participant's RS Record contains a Rehabilitation Supports Summary Note for each day that RS were received	Review RS Record to confirm presence of a Rehabilitation Supports Summary Note *(RS Form 7)* for each day of service documenting date and location, beginning and ending time of face-to-face contact, goal(s) and objective(s) addressed, method(s) of intervention, consumer's response and general progress, and future plan for IPOC implementation. *RS Form 7* must be signed by the RS Specialist and RS Coordinator. Signature by the participant or representative is optional. Source: Rehabilitation Supports Manual

G5-06	The participant's RS Record contains a Rehabilitation Supports Monthly Progress Summary for each month that RS were received	Review RS Record to confirm presence of a Rehabilitation Supports Monthly Progress Summary *(RS Form 8)* for each month of service documenting Units of Service provided, progress/status of participant, efforts of RS Specialist(s) to implement the participant's IPOC, date of staff meeting, problems/issues, recommendations of the RS Coordinator, and future action. *RS Form 8* must be signed by the RS Coordinator and RS Specialist(s). If the RS Coordinator is not a "Licensed or Master's Level Clinical Professional" as defined by SCDHHS *(RS Manual – Appendix A)*, it must be co-signed by a Clinical Professional. Source: Rehabilitation Supports Manual
G5-07	RS service provision billed to SCDDSN is substantiated in the participant's RS Record	Review copies of Rehabilitation Supports Report of Service *(RS Form 6)* and Summary Invoice for Rehabilitation Supports Provided *(RS Form 6 Summary)* and verify these are consistent with documentation in the participant's RS Record *(RS Form7 and RS Form 8)* for the corresponding month and days of service. Source: Rehabilitation Supports Manual

G6	Residential Services	Guidance
G6-01	The Residential Support Plan must include: a) The type and frequency of care to be provided b) The type and frequency of supervision to be provided c) The functional skills training to be provided d) Any other supports/ interventions to be provided e) Description of how each intervention will be documented	Score "Met" if, • There is a residential support plan and • The plan is within 365 calendar days old and • The plan includes a description of care to be provided. Care: Assistance with or completion of tasks that cannot be completed by the person and about which the person is not being taught (including but not limited to medical/dental care, regulation of water temperature, fire evacuation needs, etc.) • The plan includes a description of how the person is to be supervised throughout the day. Supervision: Oversight by another provided according to SCDDSN policy 510-01-DD Supervision of People Receiving Services and must be as specific and individualized as needed to allow freedom while assuring safety and welfare. • The plan includes functional skills training to assist the person with acquiring, maintaining or improving skills related to activities of daily living, social and adaptive behavior necessary to function as independently as possible. Skills training outlined within the plan should focus on teaching the most useful skills/abilities for the person according to the person's priorities. Every consideration should be given to adaptations that could make the task easier/more quickly learned. Functional: Activities/skills/abilities that are frequently required in natural, domestic or community environments. Source: Residential Habilitation Standard 4.6 Supports CQL Basic Assurances Factor 8 and Shared Values Factor 9
G6-02	A comprehensive functional assessment: A. Is completed prior to the development of the initial plan B. Is updated as needed to insure accuracy	Score "Met" if a comprehensive functional assessment has been done addressing the following areas: Self Care: a) Bowel/bladder care b) Bathing/grooming (including ability to regulate water temperature) c) Dressing d) Eating e) Ambulation/Mobility f) Need to use, maintain prosthetic/adaptive equipment. Personal Health: a) Need for professional medical care (how often, what care) b) Ability to treat self or identify the need to seek assistance c) Ability to administer own meds/treatments (routine, time limited, etc.) d) Ability to administer over the counter meds for acute illness e) Ability to seek assistance when needed. Self Preservation: a) Respond to emergency b) Practice routine safety measures c) Avoid hazards d) Manage (use/avoid) potentially harmful household substances e) Ability to regulate water temperature Self Supervision: a) Need for supervision during bathing, dining, sleeping, other times during the day b) Ability to manage own behavior Rights: Human rights are those rights established by the United Nations that all people are entitled to by virtue of the fact that they are human. Ex. Life, liberty and security of person, right not to be subjected to torture, etc. Personal finances/money: People are expected to manage their own money to the extent of their ability. Community Involvement:

		a) Extent of involvement b) Awareness of community activities c) Frequency d) Type Social network/family relationships a) Family and Friends b) Status of relationships c) Desired contact d) Support to re-establish/maintain contact Site Assessment (FOR SLP I ONLY) using SLP I Assessment Form: a) Completed annually b) Any items assessed as "NO" have a plan to address, approved by the District Office c) Process implemented 4/01/10 AND the assessment supports skills training, care and supervision objectives identified within the person's plan. AND the assessment is current i.e. accurately reflects the skills/abilities of the person. Events that may trigger an assessment update may include, but not be limited to: completion of a training objective, failure to progress on a training objective, upcoming annual plan, major change in health/functioning status such as stroke, hospitalization, etc. The assessment does not have to be re-done annually. It is acceptable to review the assessment and indicate the date of review and the fact that the assessment remains current and valid. This notation must be signed or initialed by the staff that completed the review. Source: Residential Habilitation Standard RH 4.4 Supports CQL Basic Assurances Factor 8 and Shared Values Factor 8
G6-03 W	Within 30 days of admission and every 365 days thereafter, a residential plan is developed: a) that supports the person to live the way he/she wants to live b) that reflects balance between self determination and health and safety c) that reflects the interventions to be applied	Initial plan must be developed within 30 days of admission and every 365 days thereafter. The Plan must reflect the person's priorities and a balance between self determination and health and safety. Source: Residential Habilitation Standard RH 4.5 The document," Balancing the Rights of Consumers to Choose with the Responsibility of Agencies to Protect" which is located on the extranet under Quality Assurance. Supports CQL Basic Assurances Factors 6 and 8
G6-04	The effectiveness of the residential plan is monitored and the plan is amended when: a) No progress is noted on an intervention b) new intervention, strategy, training, or support is identified; or c) The person is not satisfied with the intervention	Data should be looked at monthly to see that training has been completed as scheduled and data is collected as prescribed. Corrective action should be taken and recorded when: The plan is not implemented as written by staff; **When the intervention yields 100% accuracy the first month;** there is no correlation between recorded data and observed individual performance; the health, safety and welfare of people is not maintained, when the person is not satisfied with the intervention, etc. As a general rule, if no progress has been noted for three (3) consecutive months with no reasonable justification for the lack of progress, the strategy must be amended, and if necessary, the Plan as well. Source: Residential Habilitation Standard 4.9 Supports CQL Shared Values Factors 1 and 8, Basic Assurances Factor 8

G6-05	A quarterly report of the status of the interventions in the plan must be completed	Score "Met" if a summary of progress is done at a minimum, quarterly. The provider may elect to do monthly progress notes. If monthly progress notes are done, quarterly reports are not required. Note: Quarterly reports are to be completed and available within 10 business days of the close of the quarter. Source: Residential Habilitation Standard 4.7
G6-06	People receive training on rights and responsibilities	Score "Met" if there is documentation that training on rights and responsibilities is occurring. Training may include but not be limited to: On-going exposure to information regarding rights (ex. Agency wide focus on right of the month, rights discussions during house meetings, involvement in focus groups organized around rights, etc.). Formal training objectives on rights most important to the person (ex. How to vote) as applicable. Source: Residential Habilitation Standard RH 2.0 Supports CQL Shared Values Factors 1, 2 and Basic Assurances Factor 1
G6-07	Personal freedoms are not restricted without due process	Personal freedoms include but are not limited to: Making a phone call in private. Entertaining family/visitors in a private area. Unopened mail. Food choices Free access to the environment in which they live. Possessing a key to their bedroom and home if they so desire. Due process means human rights review of any restriction. The person must be offered the opportunity to attend the HRC meeting and have someone accompany them to assist in advocating for themselves, if they so desire. Verified by Service Notes. Source: Residential Habilitation Standard RH 2.0 535-02-DD Human Rights Committee Supports CQL Shared Values Factor 2
G6-08	People are expected to manage their own funds to the extent of their capability	People should manage their funds to the extent that they are capable. If assistance must be provided, provisions of 200-12-DD apply. The person must be actively involved in the development of their financial plan to include but not be limited to: planned purchases, weekly spending money, saving, etc. People should receive a regular accounting of their funds (amount, what it is spent for, where it is kept, how to access it, etc.) Source: Residential Habilitation Standard RH 2.0 200-12-DD Management of Funds for Individuals Participating in Community Residential Programs Supports CQL Shared Values Factors 1,3 and Basic Assurances Factor 9

G6-09	People who receive services are trained on what constitutes abuse and how and to whom to report	Score "Met" if there is documentation that training on abuse is occurring on an on-going basis. On-going training means that information about abuse/neglect is incorporated into all aspects of the training program not a one-time, large group training experience. Training may occur at meetings within residences, "rap sessions", Self-advocates meetings, etc. as well as in formal training objectives. Source: Residential Habilitation Standard RH 2.2 534-02-DD Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency. Supports CQL Shared Values Factor 1 and Basic Assurances Factor 4.
G6-10	People receive a health examination by a licensed Physician, Physician's Assistant, or Certified Nurse Practitioner who determines the need for and frequency of medical care and there is documentation that the recommendations are being followed	Score "Met" if: • the person has received an exam by a licensed physician, Physician's Assistant or Certified Nurse Practitioner • AND there is documentation that the plan of care is being followed • AND the health care received is comparable to any person of the same age, group and sex. i.e. mammogram for females 40 and above, annual pap smears, prostate checks for males over 50, etc • Health conditions such as dysphasia and GERD are ruled out before behaviors such as rumination, intentional vomiting, etc. are addressed behaviorally. • People with specific health concerns, such as seizures, people who are prone to aspirate, etc. receive individualized care and follow-up. • If the person has refused medical care, documentation of this must be in the file. • People actively participate in the management of their healthcare to the extent capable. At a minimum: o People should be offered choice o Kept informed regarding appointments and purpose o Have information regarding purpose/side effects of medications taken Supports CQL Shared Values Factors 1,3 and Basic Assurances Factor 5
G6-11	People receive a dental examination by a licensed dentist who determines The need for and frequency of dental care, and there is documentation that the dentist's recommendations are being carried out	Score Met if there is documentation that a dental exam has been done by a licensed dentist and there is documentation that the recommendations are being carried out. A person who is edentulous may be checked by a physician. Note: If a person has refused dental care, there must be documentation of this in the file. Source: Residential Habilitation Standard RH 5.0

G7	Health & Behavior Support Services	Guidance
G7-01 W	Behavior(s) that pose a risk to the person, others, the environment, or that interfere with his/her ability to function in the environment are addressed	If behaviors that pose a risk to the person, others or the environment or that interfere with the person's ability to function in the environment are being displayed, the behaviors must be addressed. Review the Plan, service notes, progress notes, critical incident reports and other documentation to determine if the problem behaviors occurred. Review documentation to determine if the behaviors were identified and are being addressed. Behaviors may be considered to be addressed if their occurrence is acknowledged and there is a plan for when the frequency of occurrence will warrant further intervention, steps are being taken to analyze and assess the behavior so that a strategy can be developed, informal strategies such as environmental changes, etc. are being tried, a BSP or guidelines are being implemented. Behaviors may also be considered addressed if there is evidence that an approved provider was sought (even if not found). More than one provider should be contacted before it can be determined that no provider is available. Source: 600-05-DD
G7-02	As needed by the person, but at least quarterly, psychotropic medications and the BSP are reviewed by the consulting psychiatrist, behavior consultant, and support team	[Psychotropic Drug Reviews] Review BSP, any psychiatrist and behavior consultant notes, and documentation of support team meetings to determine if psychotropic medications and the effectiveness of the BSP are reviewed at least quarterly for: A. Desired responses; B. Adverse side-effects; and C. Gradual decrease in drug dosage and ultimate discontinuance of the drug(s) unless clinical evidence/data is documented that this is contraindicated. Source: 600-05-DD
G7-03	In advance of the meeting, the Behavior Support provider is notified of the date, time and location of the Psychotropic Drug Review	When the person is being actively served by a provider of Behavior Support Services, the Behavior Support Services provider is notified of the date, time and location of the Psychotropic Drug Review. Source: Residential Habilitation Standards
G7-04	The specific behaviors/psychiatric symptoms targeted for change by the use of the Psychotropic medication are clearly noted	Source: 600-05-DD
G7-05	The Psychotropic Drug Review process provides for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence to the contrary is present	Source: 600-05-DD
G7-06	Consent for health care or restrictive interventions is obtained in accordance with 535-07-DD.	Review for documentation that procedures or restriction was discussed with the person and surrogate, if required, before presentation to the HRC and person was informed of his/her right to refuse and appeal. Source: 535-07-DD

G7-07	When prescribed anti-psychotic medication or other medication(s) associated with Tardive Dyskinesia, monitoring is conducted	Source: 603-01-DD, Supports CQL Basic Assurances Factors 2, 5, 6, & 8
G7-08	Recommendations made following GERD/Dysphagia screening and review	Annual Swallowing Checklist

G8	HASCI Waiver	Guidance
G8-01 R	**The Plan documents waiver supports including service name, the amount, frequency, and duration of each service, and provider type**	**For each waiver service received by the person, the Plan must document the need for the service; the correct waiver service name as listed in the Waiver Manual; the amount, frequency and duration of the service and the provider type (refer to the HASCI Waiver Document for provider types).**
G8-02	The Freedom of Choice Form is present	Review the record of those enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). If the waiver participant is over age 18 and not adjudicated incompetent but is physically unable to sign the form, the form and the service notes should indicate why signed choice was not obtained. If the person has reached the age of majority since waiver enrollment and has not been adjudicated incompetent, the waiver participant must either date and sign a new Freedom of Choice form or sign and date the original Freedom of Choice form documenting choice of waiver services in the community over institutionalization. This should be completed within 30 days of their 18th birthday. NOTE: Look at only those enrolled, re-enrolled or who turned 18 during the review period. Source: HASCI Waiver Manual
G8-03	The Initial Level of Care is present	Review the initial LOC determination to determine if it was completed prior to or on the date of Waiver enrollment. For ICF/MR Level of care, the initial Level of Care date is the "effective date" on the Certification Letter (ICF/MR Level of Care). For NF Level of Care, the initial Level of Care date is the date on the CLTC transmittal form (NF Level of Care, HASCI Form 7). NOTE: A person must be enrolled in the Waiver within 30 days of the initial Level of Care (LOC) determination. NOTE: If the person is enrolled in the Waiver within 30 days of the initial LOC determination the LOC effective date is valid for 365 days from the initial LOC date. Source: HASCI Waiver Manual

G8-04 R	**The most current Recertification is dated within 365 days of the last recertification and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days and ensure all sections of the LOC Determination are complete. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Service Coordinators for all consumers except for those persons whose eligibility determination is "Time-Limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Note: Look only at timeframes and who completed it.** **Source: HASCI Waiver Manual**
G8-05	The current Level of Care is supported by the current Plan and supporting assessments indicated on the LOC determination	Review the most current LOC determination (either a Nursing Facility Level of Care or an ICF/MR Level of Care completed) and compare it to information in the current Plan and other assessments referenced as sources for the LOC evaluation to determine if documentation supports the current Level of Care assessment. If the ICF/MR Level of Care is completed, the supporting assessments used to make the determination will be listed on the ICF/MR LOC determination and summarized in the Plan. If the Nursing Facility Level of Care is completed, the results of the determination will be summarized in the Plan. Source: HASCI Waiver Manual
G8-06	If a person refuses a Waiver service(s), the risks associated with refusing the service(s) were addressed and documented	Review service notes and other record documentation along with all the Support Plans/Plan changes or revisions completed during the review period to determine if a person participating in the HASCI Waiver refused a Waiver service. If a service was refused, review record to locate documentation that the risks associated with refusing the service were addressed and documented. Source: HASCI Waiver Manual
G8-07	Records verify that evaluations/reevaluations were completed in accordance with procedures specified in the approved Waiver	Review ICF/MR Level of Care or the Nursing Facility Level of Care in the record. For ICF/MR Level of Care, initial evaluations are requested from SCDDSN's Consumer Assessment Team. The Service Coordinator must submit a packet of information to the team to determine LOC. Re-evaluations are completed by Service Coordinators for all persons except for those persons whose eligibility determination is "time-limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these re-evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. For ICF/MR Level of Care Re-evaluations, the date the Level of Care Re-evaluation is completed, is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 and expiration date of 7/2/09. For Nursing Facility (NF) Level of Care, SCDHHS Community Long Term Care (CLTC) conducts initial evaluations. The Service Coordinator is responsible for obtaining consent from the potential Waiver participant and forwarding the consent and transmittal request to CLTC. DDSN Service Coordination staff completes NF Level of Care re-evaluations. For NF Level of Care re-evaluations, contact notes must reflect that the reevaluation occurred on a home visit with the Waiver participant and the reevaluation was staffed with the Service Coordination Supervisor or other responsible party within 2 working days of the home visit as verified by initial and date of the supervisor on DHHS Form 1718 (NF/LOC document). The staffing date is the NF LOC date.

G8-08	If the person was disenrolled / terminated from the HASCI Waiver, the Termination (HASCI Form 8) was completed within 2 working days of the disenrollment date	Review the service notes, the Support Plan, Plan changes/revisions and Termination form to ensure that the Service Coordinator completed the form within 2 working days of notification that the Waiver participant needed to be disenrolled. Source: HASCI Waiver Manual
G8-09 W	Documentation is present verifying that a choice of providers was offered to the person or his/her legal guardian for each HASCI Waiver service	Review the service notes and the person's Plan to determine if the person or guardian was given a choice of provider of service. Source: HASCI Waiver Manual
G8-10	The Acknowledgement of Choice and Appeal Rights is completed prior to Waiver enrollment and on an annual basis	Review the record to ensure that the Acknowledgement of Choice and Appeal Rights (HASCI Form 19) is present. Review signature dates on the forms to ensure they were completed prior to Waiver enrollment and on an annual basis. Source: HASCI Waiver Manual
G8-11	The Acknowledgement of Rights & Responsibilities is present	Review the record to ensure that the Acknowledgement of Rights and Responsibilities (HASCI Form 20) is present. This must be completed "one-time" at the Plan meeting. For new Waiver participants it must be completed prior to Waiver enrollment. It is not required annually. Persons will not have this form on record prior to December 2004 Score "Met" in this case. Source: HASCI Waiver Manual
G8-12	Waiver services are provided according to provisions in the service definitions in the Waiver document	Review Service definitions in the HASCI Waiver document for each service that the person is receiving. Review the person's Support Plan, Plan changes/revisions and service notes to ensure that services are being provided according to the definitions. Source: HASCI Waiver Manual
G8-13 R	**If Nursing Services are provided, an order from the physician is present and coordinates with the Authorization of Services Form (HASCI Form 12-D)**	**Review record to ensure that a Physician's Order for Nursing Services (Form 15) is available and is consistent with the amount and type of Nursing Services authorized for the person.** **Source: HASCI Waiver Manual**
G8-14 R	**Evidence that services are not available under the VR program is present if individual receives Supported Employment or Prevocational services**	**Review the record to determine if the individual is receiving Supported Employment or Prevocational services through the HASCI Waiver. If either service is received, review record to locate documentation supporting that this service is not available under a VR program for the person.** **Source: HASCI Waiver Manual**
G8-15	HASCI Waiver services are received at least every 30 days	Review services notes, the person's Support Plan, and Plan changes/revisions to ensure that the person has received or is receiving at least one Waiver service each month during the review period. A service must be received during each calendar month. If at least one service was not received each month, the person should have been disenrolled from the Waiver. For example, if a Waiver participant receives a Waiver service on March 17th and receives no other Waiver services before April 30th, then the Waiver participant would be dis-enrolled from the Waiver. Source: HASCI Waiver Manual

G8-16 W	Service needs and personal goals outside the scope of Waiver services are identified in the Support Plans and addressed	Review the Support Plan, Plan changes/revisions, service notes, and other documentation in the record to ensure that the Service Coordinator has identified and addressed all service needs and personal goals for the person, regardless of the funding source. Source: HASCI Waiver Manual
G8-17	Authorization forms are completed for services, as required, prior to service provision	Authorization for Services forms are present and note a "start date" for services that should be the same or after the date of the Service Coordinator's signature. Authorization forms are required for all services except Prescribed Drugs. Source: HASCI Waiver Manual
G8-18 W	The established Waiver documentation index is followed	Review the Waiver information in the record and compare it to the established HASCI Waiver documentation index. Source: HASCI Waiver Manual
G8-19	Service notes reflect Monitorship within 2 weeks of the start date of an ongoing service or provider change and include the usefulness, effectiveness, frequency, duration and the person or his / her legal guardian's satisfaction with the service	Review service notes, the Support Plan, Plan changes/revisions and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service. If so, review contact notes, the Support Plan, Plan changes/revisions and other documentation in the record to determine if service or provider change was monitored within 2 weeks and documentation regarding the usefulness, effectiveness, frequency, duration and the person~~/~~ or his/her legal guardian's satisfaction with the service is present. Source: HASCI Waiver Manual
G8-20	One-Time Services: service notes reflect contact with the person or his/her legal guardian within 2 weeks of the service and reflect that the service was received	Review service notes, the Support Plan, Plan changes/revisions and service authorizations to determine if the person or his/her legal guardian received any one-time services during the review period. If so, review the contact notes to determine if the service was monitored within 2 weeks to determine if the person received the service and provides a statement of usefulness, effectiveness and the person's satisfaction with the service. Source: HASCI Waiver Manual

G8-21	Service notes reflect an on-site visit for Environmental Modifications within 2 weeks following completion	Review service notes, the Support Plan, Plan changes/revisions and service authorizations to determine if an environmental modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date. Also review documentation to ensure support of the usefulness and effectiveness of the service along with the person's or his/her legal guardian's satisfaction with the service. Source: HASCI Waiver Manual
G8-22	Service notes reflect an on-site visit for Private Vehicle Modifications within 2 weeks of completion	Review service notes, the Support Plan, Plan changes/revisions and service authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date and documentation is available to support the usefulness, effectiveness, and benefit of the service along with the person's or his/her legal guardian's satisfaction with the service. Source: HASCI Waiver Manual
G8-23	For any one-time service that costs $1500.00 or more, the Service Coordinator has made an on-site visit to observe the item and to document the item's usefulness and effectiveness	Review service notes, the Support Plan, Plan changes/revisions and service authorizations to determine if any one-time service costing over $1500.00 was provided during the review period. If so, review the service notes to determine if the item was monitored on-site by the Service Coordinator and documentation is available to support the usefulness, effectiveness, and benefit of the service along with the person's or his/her legal guardian's satisfaction with the service. Source: HASCI Waiver Manual
G8-24	Waiver Tracking System is consistent with records regarding services and the Plan includes and justifies the need for all HASCI Waiver services	Review the Waiver services listed in the Support Plan and Plan changes/revisions and compare them with the services listed on the Waiver tracking system. Also review the service authorizations and Medicaid Paid Claims to ensure that all Wavier Services are included and supported in the person's Plan. Source: HASCI Waiver Manual
G8-25	The Person / Legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of Waiver services with accompanying appeals information	Review service notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate appeals process. Source: HASCI Waiver Manual
G8-26	For HASCI Waiver funded services provided by the Board (also called Board-based services), documentation is available to show the service was provided on the date the service was reported	Behavioral Support Services or Behavioral Support; Psychological Services or Psychological; Health Education for Consumer-Directed Care or Health Education; Peer Guidance for Consumer-Directed Care or Peer Guidance: look for a copy of the license, certificate or Service Note that shows the provider is licensed or certified/trained. "Individual Summary of Caregiver Services Provided: reflects the amount of services provided. The Support Plan reflects the need for the service. Review the progress notes/comments of the provider of the service to ensure services are being provided as authorized. Data/documentation is available to show that needed services/interventions were provided at each visit. Environmental modifications, Environmental Mods., or Enviro Mods.; Private Vehicle Modifications, Vehicle Modifications or Vehicle Mods.: A copy of an invoice for the work with person's name and notation that the work is complete. NOTE: Not needed if direct billed. - The Plan must reflect the need for the modification and general description of the work to be completed. For Environmental Modifications, a licensed contractor must be used. Look for the license number issued by the SC Labor Licensing and Regulation (SCLLR). NOTE: An automatic door system or grab bars may be installed by a

		licensed contractor or a vendor with a retail or wholesale business license contracted to provide the service(s); for ex., a Durable Medical Equipment vendor. NOTE: All adaptations/modifications to the home that require building any type for example, using hammer and nails must be done by contractors that are licensed by the State of South Carolina through the SC Department of Labor, Licensing and Regulation, Contractor's Licensing Board. For Private Vehicle Modifications, the technician or professional must be trained in the installation and repair of manufacturer's equipment. Look for a copy of the certificate or Service Note that shows the technician reports that he/she has been trained/certified. Personal Emergency Response Systems, Personal Emergency Response System, or PERS; Medical Supplies, Equipment and Assistive Technology, Medical Supplies, Medical Equipment or Assistive Technology: look for a copy of an invoice for the system, the medical supplies or piece of equipment and notation that the system, medical supplies or equipment was received. Attendant Care/Personal Assistance Services, Attc/PAS, Attendant Care Services, Attendant Care, Attc, Personal Assistance or Personal Assistance Services; Medicaid Waiver Nursing Services, Nursing Services or Nursing: look for a copy of the Daily Log or Time Sheet (documentation) by the attendant (for attendant care services) or nurse (from nursing services) that is available to show that the services were provided as authorized. The Support Plan must justify the need for assistance with activities of daily living and personal care for attendant care services. For nursing services, the Support Plan must justify the need for the services as ordered by the physician. Source: HASCI Waiver Manual
G8-27	Documentation is present verifying that a provider is being actively sought when a provider is unavailable for any Waiver Service	Review the service notes and the person's Plan to determine if the Service Coordinator is actively seeking a provider of a Waiver service when a provider has not been found to provide the service. Source: HASCI Waiver Manual
G8-28	Nurse supervisory reports are present for attendant care services and the Support Plan includes the need, frequency and intensity of the supervision	Review the Support Plan to assure it includes the need for supervision or a statement that the person or responsible party is able to direct his/her care (this information will be included in the Service Coordinator's Responsibilities section of the Support Plan (Section D of the Support Plan) Note: Review nurse (LPN or RN licensed to practice in the state) supervisory progress reports. Nurse supervisory reports must be received and reviewed by the Service Coordinator. Nurse supervisory reports are completed at least once every four months unless there is a statement that the person or responsible party is able to direct his/her own care. The four (4) month supervisory visit must be completed by the end of the fourth month. Note: The attendant care provider should be allowed time to submit the nurse supervisory report to the DSN Board or Non-Board provider after the four (4) month supervisory visit is completed. Look for a copy of the nurse's license in the file or review contact notes documenting the license # of the nurse. NOTE: Nurse supervisory reports are not required for a consumer receiving UAP (University Affiliated Project) Attendant Care Services. A person receiving UAP Attendant Care Services must be able to self-direct his/her own care or designate a responsible party (RP) that is able to direct the person's care. The Support Plan does not need to include the frequency and intensity of nurse supervision for UAP Attendant Care Services. NOTE: Supervision may be furnished directly by the person or responsible party when the individual or responsible party has been trained to perform this function and when the safety and efficacy of person-provided supervision has been certified in writing by a registered nurse (RN) or otherwise provided by State law. This certification must be based on direct observation of the person/responsible party and the

		specific attendant care/personal assistance provider during the actual provision of care. Documentation of this certification must be maintained in the person's file and will be documented in the Plan. Source: HASCI Waiver Manual
G8-29	Documentation is present verifying that the Attendant Care Daily Logs for a person receiving UAP Attendant Care Services are present in the record and received at least monthly by the Service Coordinator	Review the service notes, the person's Support Plan, Plan changes/revisions and any other record documentation to ensure that the Service Coordinator has received a copy of the Attendant Care Daily Logs at least monthly from the UAP attendant. Source: HASCI Waiver Manual

G9	MR/RD Waiver	Guidance
G9-01	Assessment(s) justify the need for all MR/RD Waiver services included on the plan	Review the Plan, DDSN Service Coordination Annual Assessment, service assessments (e.g. ADHC Assessment of Need, PC/Attendant Care Assessment, etc.) and service notes to ensure that all MR/RD Waiver services included on the Plan are supported by assessed need. Source: MR/RD Waiver Manual
G9-02 R	**The plan includes MR/RD Waiver service(s) name, frequency of the service(s), amount of service(s), duration of service(s) and valid provider type for service(s)**	**For each waiver service received by the participant, the plan must document the need for the service; the correct waiver service name, the amount, frequency, duration and the provider type [refer to the MR/RD Waiver Document for provider types (Chapter 2 of MR Waiver Manual)].** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" for Respite, "per week" or "weekly" for Personal Care).** **Note: Regarding "duration" check only that a duration is specified.** **Source: MR/RD Waiver Manual**
G9-03	The Freedom of Choice Form is Present	Review the record of those enrolled or re-enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). For forms completed during the review period, if the waiver participant is over age 18 and not adjudicated incompetent but is physically unable to sign the form, the form and the service notes should indicate why signed choice was not obtained. If the participant has reached the age of majority since waiver enrollment during the review period and has not been adjudicated incompetent, the waiver participant must either date and sign a new Freedom of Choice form or sign and date the original Freedom of Choice form documenting choice of waiver services in the community over institutionalization. This should be completed within 90 days of their 18th birthday. NOTE: Look at only those enrolled, re-enrolled or who turned 18 during the review period. Source: MR/RD Waiver Manual
G9-04 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Service Coordinators for all consumers except for those participants whose eligibility determination is "Time-Limited", or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Note: Look only at timeframes and who completed it.** **Source: MR/RD Waiver Manual**

G9-05	The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination	Review the most current LOC determination and compare it to information in the assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment. Note: Look only at lines on LOC assessments Source: MR/RD Waiver Manual
G9-06 R	**The Current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete with appropriate responses.** **Note: Ensure that all areas are complete or checked.** **Source: MR/RD Waiver Manual**
G9-07 W	Documentation is present verifying that a choice of provider was offered to the participant/ family for each new MR/RD Waiver service	Review the service notes and the participant's Plan to determine if the participant was given a choice of provider of service each time a new service was authorized. Source: MR/RD Waiver Manual
G9-08	Acknowledgment of Rights and Responsibilities (MR / RD Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by participant or legal guardian, if applicable) on the current and previous forms to ensure they have been completed annually (within 12 months of the previous form). Source: MR/RD Waiver Manual
G9-09	MR/RD Waiver services are provided in accordance with the service definitions found in the Waiver document	Review Service definitions in the MR/RD Waiver document (Chapter 2 of the MR/RD Manual) for each service that the participant is receiving. Review the participant's Plan, service notes and relevant service assessments to ensure that services are being provided according to the definitions. Source: MR/RD Waiver Manual
G9-10 R	**If Nursing Services are provided, an order from the physician is present and is consistent with the authorization form (MR/RD Form A-12)**	**Review record to ensure that a physician's order is available and is consistent with the type of Nursing Services authorized for the participant (RN or LPN).** **Note: Do not look at Nursing Services for children (State Plan Service).** **Source: MR/RD Waiver Manual**
G9-11	MR/RD Waiver services are received at least every 30 calendar days	Review service notes and Plan to ensure that the participant has received or is receiving at least one MR/RD Waiver service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 calendar days, the participant should have been disenrolled from the Waiver. Note: Children's PCA and Private Duty Nursing do not count, as they are State Plan Medicaid Services. Source: MR/RD Waiver Manual
G9-12 W	Service needs outside the scope of Waiver services are identified in Plans and addressed	Review the Plan, service notes, and other documentation in the record to ensure that the Service Coordinator has identified and addressed all service needs regardless of the funding source. Source: MR/RD Waiver Manual

G9-13	Authorization forms are properly completed for services as required, prior to service provision	Review the participant's plan, and ensure that authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Service Coordinator's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS-enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. Authorization forms are required for all services except Prescribed Drugs, Adult Vision Services, Adult Dental Services, and an Audiological Evaluation. Source: MR/RD Waiver Manual
G9-14	Service notes reflect monitorship within the first month of the start of an ongoing MR/RD Waiver service or provider change	Review the Plan, service notes, and service authorizations to determine if the participant began receiving a new ongoing service and/or changed providers of a previously received ongoing service during the review period. If so, review service notes, the Plan and other documentation in the record to determine if the service was monitored within 1 month of the start date or provider change. Source: MR/RD Waiver Manual
G9-15	Service notes reflect monitorship within the second month from the start of an ongoing MR/RD Waiver service or provider change	Review the Plan, service notes and service authorizations to determine if the participant began receiving a new ongoing service and/or changed providers of a previously received ongoing service during the review period. If so, review service notes, the Plan and other documentation in the record to determine if the service was monitored within the second month of the start date or provider change. Source: MR/RD Waiver Manual
G9-16 W	Service notes reflect on-site monitorship of Adult Day Health, Adult Attendant Care, Personal Care, and/or Nursing, while service is being provided. This monitorship must occur within 1 month of the start of service (within 2 weeks of start of Adult Attendant Care Services) or provider change and once yearly unless otherwise noted by supervisor exception and documented approval	Review service notes, the Plan, and other documentation in the record to determine if documentation is available to support that an on-site visit was provided as required for each applicable Waiver service the participant is receiving. If an exception is noted, documentation must be available noting why and must be only for extreme circumstances (i.e., the service is only provided in extremely early or late hours). NOTE: If service is provided before 7 am or after 9 pm, on-site monitorship is not required. Source: MR/RD Waiver Manual
G9-17	Service notes reflect monitorship with the recipient within 2 weeks of a one-time service and reflect the service was received	Review service notes, the Plan and service authorizations to determine if the any one-time services were received during the review period. If so, review the service notes to determine if the service was monitored within 2 weeks of receipt to determine if the participant received the service. Source: MR/RD Waiver Manual
G9-18	Services notes reflect an on-site monitorship of environmental modifications within 2 weeks of completion	Review service notes, the Plan, and service authorizations to determine if an environmental modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date. Source: MR/RD Waiver Manual

G9-19	Service notes reflect an on-site monitorship of private vehicle modifications within 2 weeks of completion	Review service notes, the Plan, and service authorizations to determine if a private vehicle modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date. Source: MR/RD Waiver Manual
G9-20	Service notes reflect an on-site monitorship, if hearing aid is provided, within 2 weeks of the participant receiving the aide(s)	Review service notes, the Plan and service authorizations to determine if a hearing aid was provided during the review period. If so, review the service notes to determine if monitorship was provided on-site by the Service Coordinator within 2 weeks of the date of receipt or notification of service by consumer. Source: MR/RD Waiver Manual
G9-21	For any one-time assistive technology item costing $2500.00 or more, the Service Coordinator has made an on-site visit to observe the item	Review service notes, the Plan and service authorizations to determine if any one-time assistive technology item costing over $2500.00 was provided during the review period. If so, review the service notes to determine if the item was seen in the recipient's possession by the Service Coordinator. Source: MR/RD Waiver Manual
G9-22	The Participant/Legal Guardian (if applicable) was notified in writing regarding any denial, termination, reduction, or suspension of MR/RD Waiver services with accompanying reconsideration/appeals information	Review service notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the participant/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate reconsideration/appeals process. Note: If the participant/legal guardian (if applicable) requested to terminate, suspend, or reduce the service, this Indicator is N/A Source: MR/RD Waiver Manual

G10	PDD Program	Guidance
G10-01	PDD Waiver participants must meet all eligibility criteria	Review the record to determine if the child meets the criteria for services through the PDD Program: • Be ages 3 through 10 years. • Diagnosed with a PDD by age eight years. The diagnosis must be made by a qualified, licensed or certified diagnostician. Children who are currently eligible for DDSN under the Autism Division must meet these criteria. • Meet Medicaid financial criteria or provide documentation of financial ineligibility for Medicaid. • Meets ICF/MR Level of Care medical criteria (as determined by the DDSN Consumer Assessment Team for this program). Note: Children who do not meet ICF/MR Level of Care, but meet all other eligibility requirements may receive services outside the waiver through the State Funded PDD program if funding is available. Source: PDD Waiver Manual
G10-02	The Freedom of Choice Form is present for PDD Waiver recipients	Review the record to ensure that the Freedom of Choice form is present in the record. The form must be "checked" to indicate choice of Waiver services in the community over institutionalization and signed by the child's parent/legal guardian.
G10-03	The Initial Level of Care is present	Review the initial LOC determination to determine if it was completed prior to or on the date of Waiver enrollment.
G10-04 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the Consumer Assessment Team**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. The Case Manager must submit a packet of information to the team to determine LOC. Reevaluations are completed by the Consumer Assessment Team. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2003 the effective date would be 7/3/03 with an expiration date of 7/2/04.**
G10-05 W	Documentation is present verifying that a choice of providers was offered to the child's parents/legal guardians for each PDD service	Review the contact notes, the child's Plan and other file documents to determine if the parents/legal guardians were given a choice of provider of service before the service (i.e. Case Management and EIBI) was authorized.
G10-06	The Acknowledgment of Rights and Responsibilities is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates on the current and previous forms to ensure they have been completed annually.
G10-07	PDD services are provided in accordance with the service definitions	Review Service definitions in the PDD Manual for each service that the child is receiving. Review the child's Plan, contact notes and relevant service authorizations to ensure that services are being provided according to the definitions. Note: Correct terminology is required (example: "EIBI" not ABA)

G10-08	For PDD Waiver recipients, PDD Waiver services are received at least every 30 days	Review services notes and the Plan to ensure that the person has received or is receiving at least one Waiver service every 30 days during the review period. A service must be received at least every 30 days. If at least one service was not received every 30 days, the person should have been disenrolled from the Waiver.
G10-09	Authorization forms are completed for services, as required, prior to service provision	Review the child's budget and Plan to ensure that Authorization for Services forms are present and note a "start date" for services that is the same or after the date of the Case Manager's signature. Authorization forms are required for all services.
G10-10	The Person/Legal Guardian was notified in writing regarding any denial or termination of PDD services with accompanying appeals information	Review contact notes to determine if during the review period any Waiver services were reduced, suspended, terminated or denied. If this is noted, then review the contact notes to determine if the parent/legal guardian was notified in writing and provided with the appropriate appeals process.
G10-11	The Plan clearly includes and justifies the need for all PDD Waiver services received	Review the Plan, service authorizations to ensure that all PDD Waiver services are included and supported by assessed need in the child's Plan. Services should be identified and provided according to PDD Waiver service definitions. • Each need is to be addressed separately. • The term "PDD" should be used to introduce the service (e.g. PDD Assessment, PDD Plan Implementation, etc.)
G10-12	The record must reflect that the child's parent/legal guardian was offered the opportunity to participate in planning	Review the Case Management record to ensure the child's parent/legal guardian was afforded the opportunity to participate in planning. This should be demonstrated in the record by inviting the child's parent/legal guardian to meet to discuss plans, by scheduling the meeting (If a meeting is chosen) at a time and location that facilitated participation, by soliciting input prior to the actual meeting if attendance is not possible, or by allowing participation in the meeting by phone or other means. The requirement is that the opportunity be afforded, not that participation occur.
G10-13	The parent/legal guardian was provided a copy of the Plan	Review the service notes to verify that the child's parent/legal guardian was provided a copy of the Plan.
G10-14	Case Managers who serve children in the PDD Program must meet the minimum requirements for the position	Determine from personnel records if the minimum requirements for employment were met. Refer to the contract between SCDHHS and SCDDSN (amended January 2010) pertaining to The Purchase and Provision of Home and Community-Based Pervasive Developmental Disorder Waiver Services.
G10-15	Records include documentation of verification that Case Managers are free from tuberculosis	Review TB results of each Case Manager from personnel sample. Check documentation for the following: • Must have a PPD Tuberculin skin test no more than ninety (90) days prior to employment, unless a previously positive reaction can be documented. Must have a PPD Tuberculin skin test no more than ninety (90) days prior to employment, unless a previously positive reaction can be documented. • In lieu of a PPD tuberculin test no more than 90 days prior to employment, a new employee may provide certification of a negative tuberculin skin test within the 12 months preceding the date of employment and certification from a licensed physician or local health department TB staff that s/he is free of the disease.

		• Employees with negative tuberculin skin tests shall have an annual tuberculin skin test. • New employees who have a history of tuberculosis disease and have had adequate treatment shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared non-contagious. Refer to the contract between SCDHHS and SCDDSN pertaining to The Purchase and Provision of Home and Community-Based Pervasive Developmental Disorder Waiver Services, Appendix B, Case Management Services, Conditions of Participation, item # 6.
G10-16	Case Managers will provide at least 1 monthly contact with the EIBI service providers and/or family to determine progress/lack of progress on established goals and/or person satisfaction with EIBI providers	Review contact notes in the records to determine if the parents and/or provider has been contacted monthly. Review established goals and monthly progress reports received from the provider to determine progress or the lack of progress. Review contact notes to determine if Case Manager received complaints from families about provider services and, if the Case Manager discussed the concerns with the provider.
G10-17	Case Managers will contact the child's family quarterly	Review contact notes and other documentation to determine: • If the family received quarterly contact from the Case Manager • If the entire Support Plan was reviewed and discussed • If the most recent EIBI service provider quarterly data report was reviewed and discussed
G10-18 W	Case Managers will have at least one face-to-face contact visit with the child and their family annually	Review service notes in the Case Management record to determine if the child served has received face-to-face-contact by the Case Manager at least once per Plan year during each 365-day period.
G10-19 R	**Case Managers will ensure the Plan is developed, reviewed and approved every 365 days or more often if needed**	**Review current Plan in the child's record. A current Plan must be present and signed by the Case Manager. A current Plan is defined as one completed within the last 365 days. A Plan must be completed:** • **Within 365 days of the last plan** • **Before PDD Services are authorized or provided**

G10-20 R	**Case Managers are responsible for preparing and submitting all documents needed for timely determination of the ICF/MR LOC by the Consumer Assessment Team. The most current Level of Care Determination is dated within 365 days of the last Level of Care determination**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. The Case Manager must submit a packet of information to the team to determine LOC. Reevaluations are completed by the Consumer Assessment Team. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2003 the effective date would be 7/3/03 with an expiration date of 7/2/04.**
G10-21	Case Managers must document all activities in the child's record	Contact notes must include the following: name and title of contact person, type of contact, location of contact, purpose of contact, intervention or services provided, the outcome, needed follow-up, and the date and signature of the Case Manager.
G10-22	Case Managers must document the date on which the child's referral was first received and the date all actions taken thereafter	Review contact notes to determine if the family's initial choice of a Case Management provider was documented. Review the records for the Choice of Provider form and ensure it was signed and dated by the child's parents/legal guardians. Review the notes to ensure all subsequent entries are dated.
G10-23	Case record documentation must reflect that the child's parents were given information on all EIBI qualified providers in the State and given guidance on which providers are in close proximity to the parent/legal guardian's community	Review the contact notes and the person's Plan to determine if the parent/legal guardian was given information on all EIBI qualified providers in the State of South Carolina and given guidance on which providers are in close proximity to the parent/legal guardian's community.
G10-24	Case Managers must utilize required forms, completed properly, and they must include the required signatures	Review the PDD Manual including the index of forms. Compare this to the actual documents found in the person's file to determine proper usage. Review all documents for signatures and dates as required.
G10-25	Case Manager's must assure, and records must reflect that each child's parent has been provided with information about how to file a complaint	Review records to ensure that parents are provided information on the Reconsideration/Appeals Process at least annually and at any relevant action such as termination or denial of services.

G10-26	Case Managers are required to attend at least one in-service training annually related to autism and the provision of case management to individuals enrolled in the PDD Waiver. The training must be facilitated by the Autism Division	Review documentation in the personnel file to ensure annual training occurred as required.
G10-27 W	Case Management records are maintained and include required information	Review the Case Management record to determine if records include the following: • A current Single/Support Plan (After 7/1/07 the Support Plan will be used) • Current IEP (for school age children) It is only required to • Obtain a new/current IEP during annual Service Coordination plan development. • Service Notes (when reviewing service notes, check to make sure that service notes are typed or handwritten in black or dark blue ink, legible, in chronological order, entries dated and signed with the date, Service Coordinator's name and title or initials (a signature/initial sheet must be maintained at the Service Coordination provider's office), if abbreviations or symbols are used, there is a list of any abbreviations or symbols maintained at the Service Coordination provider's office, persons referenced are identified by their relationship to the person receiving services either at least once on each page or on a separate list located in each record, proper error correction procedures are followed if errors have occurred and no correction fluid or erasable ink was used)

G10	EIBI Providers Only	Guidance
G10-28	All individuals who serve as the EIBI Consultant must meet requirements	Review personnel files for documentation, credentials and written evidence to support and demonstrate that employees meet the minimum requirements for the position in which they serve. All individuals who serve as the EIBI Consultant must meet the following requirements: • A master's degree in behavior analysis, education, psychology, or special education; and • Current certification by the Behavior Analyst Certification Board as a Board Certified Behavior Analyst (BCBA); and • At least one year of experience as an independent practitioner; and • Successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the DDSN interview team **or** • A bachelor's degree in behavior analysis, education, psychology, or special education; and • Current certification by the Behavior Analyst Certification Board as a Board Certified Associate Behavior Analyst (BCABA); and • At least two years of experience as an independent practitioner, and • Successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the DDSN interview team; or • A bachelor's degree in behavior analysis, education, psychology, or special education; and • At least three years of experience as an independent practitioner; and Successfully complete the initial approval process which includes an interview and the submission of a Work Sample that is reviewed and critiqued for competency by the DDSN interview team.
G10-29	All individuals who serve as Lead Therapists must meet requirements	Review personnel files for documentation, credentials and written evidence to support and demonstrate that employees meet the minimum requirements for the position in which they serve. All individuals who serve as Lead Therapist must meet the following requirements unless an exception has been granted by DDSN: • A bachelor's degree in behavior analysis, education, psychology, or special education; and • Has at least 500 hours of supervised line therapy or supervised experience in implementing behaviorally based therapy models consistent with best practices and research on effectiveness, for children with Pervasive Developmental Disorder to include autism and Asperger's disorder. If an exception has been granted, there must be written evidence from DDSN.

G10-30	All individuals who serve as Line Therapists must meet requirements	Review personnel files for documentation, credentials and written evidence to support and demonstrate that employees meet the minimum requirements for the position in which they serve. All individuals who serve as Line Therapists must meet the following requirements: • Be at least 18 years old and a high school graduate; • Be able to speak, read and write English; • Have documentation of receiving the required training as listed below prior to providing a service: a. Current First Aid Certification (must be renewed at least every three years) b. Current CPR Certification (must be renewed annually) c. Confidentiality, Accountability, and Prevention of Abuse and Neglect d. At least 12 hours of training in the implementation of applied behavior analysis to include at least 3 hours of autism and PDD specific training • Have documentation of receiving the required annual in-service training of at least 5 hours in the implementation of applied behavior analysis, autism or PDD specific training. • Have documentation of a clear background check conducted by the provider prior to providing a service and at least annually thereafter in the following areas: a. Not listed in the DSS Child Abuse Central Registry b. Have no felony convictions as determined by an officially obtained SLED report c. Provide a copy of current, valid driver's license (If no driver's license submit a copy of an Official State ID Card) d. PPD Tuberculin Test
G10-31	There must be documentation those individuals / entities that are on the qualified provider list for EIBI services completed the initial approval process	All EIBI providers should have the following documentation on file for the initial approval process: • A completed Early Intensive Behavior Intervention Provider Application (must be signed and dated) and all required attachments (e.g. a current curricula vita and 1) an educational / behavioral testing evaluation (preferably the ABLLS), 2) an educational program or program example to include data / graphs and progress updates and, 3) a Behavioral Support Plan to include a Functional Assessment for which you have written / developed and implemented for an individual with a Pervasive Developmental Disorder. • The Provider Approval Letter • The Provider Pre-Enrollment Information for Participation in the Pervasive Developmental Disorder Waiver Program form • The W-9 • The Medicaid Enrollment Form • The EIBI Certification Letter
G10-32	Individuals / entities that become approved providers of EIBI services submit required data to the child's Case Manager and the Autism Division within the timeframes specified	Review the child's records to determine the date services began and look for data reports that correspond to that date: • Progress reports: must be submitted monthly and demonstrate/document that drills are conducted as scheduled • Data reports: must be submitted quarterly and contain cumulative graphs of target areas demonstrating progress or areas of concern

G10-33	Individuals / entities that become approved providers of EIBI services submit required assessments to the child's Case Manager and the Autism Division within the timeframes specified	Review the child's records to determine the date services began and look for assessments that correspond to that date: • Assessment of Basic Language and Learning Skills (ABLLS): must be submitted semi-annually per the initial assessment date • Peabody Picture Vocabulary Test (PPVT) and Vineland: must be submitted annually per the initial assessment date

G-11	Community Supports Waiver	Guidance
G11-01	Assessment(s) justify the need for all COMMUNITY SUPPORTS Waiver services included on the plan	Review the Plan, DDSN Service Coordination Annual Assessment, and service notes to ensure that all COMMUNITY SUPPORTS Waiver services included on the Plan are supported by assessed need. Source: COMMUNITY SUPPORTS Waiver Manual
G11-02 R	**The Plan includes COMMUNITY SUPPORTS Waiver service/s name, frequency of service/s, amount of service/s, duration of service/s, and valid provider type for service/s**	**For each waiver service received by the person, the plan must document the need for the service, the correct waiver service name, the amount, frequency, duration and the provider type (refer to the COMMUNITY SUPPORTS Waiver Document for provider types/Chapter 2, CSW Manual)** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" for Respite, "per week" or "weekly" for Personal Care).** **Note: Regarding "duration" check only that a duration is specified.** **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-03	The Freedom of Choice Form is Present	Review the record of those enrolled or re-enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). For forms completed during the review period, if the waiver participant is over age 18 and not adjudicated incompetent but is physically unable to sign the form, the form and the service notes should indicate why signed choice was not obtained. If the person has reached the age of majority since waiver enrollment during the review period and has not been adjudicated incompetent, the waiver participant must either date and sign a new Freedom of Choice form or sign and date the original Freedom of Choice form documenting choice of waiver services in the community over institutionalization. This should be completed within 90 days of their 18th birthday. Note: Look at only those enrolled, re-enrolled or who turned 18 during the review period. Source: COMMUNITY SUPPORTS Waiver Manual
G11-04 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Service Coordinators for all consumers except for those persons whose eligibility determination is "Time-Limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these evaluations. If the**

		re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09. **Note: Look only at timeframes and who completed it.** **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-05	The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination	Review the most current LOC determination and compare it to information in the assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment. Note: Look only at lines on the LOC Assessment Source: COMMUNITY SUPPORTS Waiver Manual
G11-06 R	**The Current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete.** **Note: Ensure that all areas are complete with appropriate responses.** **Source: COMMUNITY SUPPORTS Waiver Manual**
G11-07	Documentation is present verifying that a choice of provider was offered to the person/ family for each new COMMUNITY SUPPORTS Waiver service	Review the service notes and the person's Plan to determine if the person was given a choice of provider of service each time a new service need was identified/ authorized. Source: COMMUNITY SUPPORTS Waiver Manual
G11-08	Acknowledgment of Rights and Responsibilities (CSW Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by person or legal guardian, if applicable) on the current and previous forms to ensure they have been completed annually (within 12 months of the previous form). Source: COMMUNITY SUPPORTS Waiver Manual
G11-09	COMMUNITY SUPPORTS Waiver services are provided in accordance with the service definitions	Review Service definitions in the COMMUNITY SUPPORTS Waiver document for each service that the person is receiving. Review the person's Plan, service notes and relevant service assessments to ensure that services are being provided according to the definitions. Source: COMMUNITY SUPPORTS Waiver Manual
G11-10	COMMUNITY SUPPORTS Waiver services are received at least every 30 calendar days	Review service notes and Plan to ensure that the person has received or is receiving at least one COMMUNITY SUPPORTS Waiver service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 calendar days, the person should have been disenrolled from the Waiver. Note: Children's PCA is state plan Medicaid Source: COMMUNITY SUPPORTS Waiver Manual

G11-11	Service needs outside the scope of Waiver services are identified in Plans and addressed	Review the Plan, service notes, and other documentation in the record to ensure that the Service Coordinator has identified and addressed all service needs regardless of the funding source. Source: COMMUNITY SUPPORTS Waiver Manual
G11-12	Authorization forms are completed for services as required, prior to service provision	Review the person's Plan to ensure that Authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Service Coordinator's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. Source: COMMUNITY SUPPORTS Waiver Manual
G11-13	Service notes reflect monitorship within the first month of the start of an ongoing COMMUNITY SUPPORTS Waiver service or provider change	Review the Plan, service notes, and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service during the review period. If so, review service notes, the Plan and other documentation in the record to determine if service or provider change was monitored within 1 month of the start date or provider change. Source: COMMUNITY SUPPORTS Waiver Manual
G11-14	Service notes reflect monitorship within the second month from the start of an ongoing COMMUNITY SUPPORTS Waiver service or provider change	Review the Plan, service notes, and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service during the review period. If so, review service notes to determine if service or provider change was monitored within the second month after the start date or provider change. Source: COMMUNITY SUPPORTS Waiver Manual
G11-15	Service notes reflect on-site monitorship of In-Home Support services and Personal Care while service is being provided. This monitorship must occur within 1 month of the start of service (within 2 weeks of start of In-Home Support Services) or provider change and once yearly unless otherwise noted by supervisor exception and documented approval	Review service notes, the Plan, and other documentation in the record to determine if documentation is available to support that an on-site visit was provided as required for each applicable Waiver service the person is receiving. If an exception is noted, documentation must be available noting why and must be only for extreme circumstances (i.e., the service is only provided in extremely early or late hours). NOTE: If service is provided before 7 am or after 9 pm, on-site monitorship is not required. Source: COMMUNITY SUPPORTS Waiver Manual

G11-16	Service notes reflect monitorship with the recipient within 2 weeks of a one-time service and reflect the service was received	Review service notes, the Plan and service authorizations to determine if the any one-time services were received during the review period. If so, review the service notes to determine if the service was monitored within 2 weeks of receipt to determine if the person received the service. Source: COMMUNITY SUPPORTS Waiver Manual
G11-17	Services notes reflect an on-site monitorship of environmental modifications within 2 weeks of completion	Review service notes, the Plan, and service authorizations to determine if an environmental modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date. Source: COMMUNITY SUPPORTS Waiver Manual
G11-18	Service notes reflect an on-site monitorship of private vehicle modifications within 2 weeks of completion	Review service notes, the Plan, and service authorizations to determine if a private vehicle modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Service Coordinator within 2 weeks of the completion date. Source: COMMUNITY SUPPORTS Waiver Manual
G11-19	For any one-time assistive technology item costing over $2500.00, the Service Coordinator has made an on-site visit to observe the item	Review service notes, the Plan and service authorizations to determine if any one-time assistive technology item costing over $2500.00 was provided during the review period. If so, review the service notes to determine if the item was seen in the recipient's possession by the Service Coordinator. Source: COMMUNITY SUPPORTS Waiver Manual
G11-20	The Person/Legal Guardian (if applicable) was notified in writing regarding any denial, termination, reduction, or suspension of COMMUNITY SUPPORTS Waiver services with accompanying reconsideration/appeals information	Review service notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate reconsideration/appeals process. Note: If the person/legal guardian (if applicable) requests to terminate, suspend, or reduce the service, this Indicator is N/A. Source: COMMUNITY SUPPORTS Waiver Manual

RESIDENTIAL OBSERVATION

July 2011 through June 2012

This tool is to be used by the Quality Assurance Reviewer to gather information to determine whether or not a provider is meeting requirements in the areas listed below. Information may be gathered from interactions with staff and people who receive services, by observations, and/or record review. If observation/discovery shows that the provider is meeting the requirement, a score of "Met" will be recorded. If it is determined that the provider is not meeting the requirement, a score of "Not Met" will be recorded.

	Area	Suggested sources for evidence	Comments	Met	Not Met
1	Health status and personal care needs are known and people are provided the type and degree of CARE necessary to address those needs appropriately	Via interview of staff, people, review records, observation) determine whether or not the following is occurring: • Medical conditions /health risks are known and needs are adequately addressed as outlined in the support plan. • Prescribed medications are known. • Potential side effects are known and the actions to take if side effects are noted. • Risks are identified and addressed appropriately (elopement, self-injurious behavior, seizure activity, etc.) • Food provided meets the dietary requirements (restrictions, special preparations) • People receive routine health care and dental exams. • People are referred to specialists for evaluations of seizures, GERD, orthopedic problems, etc. • There are no issues with accessing quality care. • A system is in place to address acute illness promptly and ensure appropriate follow up and staff are knowledgeable about that system. Interview people to determine if they: • are supported to choose their healthcare providers • make their own appointments if they are capable • are informed about the medications they are taking and why and possible side effects. • People are supported to be clean and well groomed.		☐	☐

2	People are provided the degree and type of SUPERVISION necessary to keep them safe but not unnecessarily restricted	Through conversation with staff and observation, determine if: • Staff knows the person's capability for managing their own behavior. • Person has a plan of supervision. • Staff can describe the plan. • Plan is carried out appropriately. For example, if staff tells you that the person must be visually checked on the hour, observe to see whether or not that occurs and that it is documented as the plan specifies. • Supervision plans are individualized. • People are not receiving more supervision than they require. • Restrictive plans of supervision are reviewed and approved by HRC		☐	☐
3	People receive assistance with acquisition, retention, or improvement in skills necessary to live in the community, consistent with assessed needs, interests/personal goals	Ask the person to tell you what they are learning and how their goals were chosen. Is training meaningful to them? Is it related to their personal goals? Are they learning new skills? Has training resulted in them becoming more independent? What changes, if any have been made in their training? . Are equipment/materials available to staff to implement plan? If applicable, this includes the individual's formal behavior support plan. Determine the staff's knowledge of the content of the plan including the targeted behaviors, interventions and replacement behaviors. Ask staff how they were trained on the behavior support plan. Are behavioral incidents being documented according to the behavior support plant? How effective is the behavior plan? How often does the behavior support person monitor the plan?		☐	☐

4	People are SAFE	Observe to see if any unsafe conditions are apparent. Are emergency numbers posted/readily available? Are fire drills conducted with individualized supports if needed i.e. flashing lights for people who cannot hear the alarm, etc.? Are people trained on emergency procedures? Ask how they would react if a fire, tornado, etc. happened. Ask staff what their responsibilities are in responding to emergency situations. Are staff familiar with safety equipment and how to operate it? Have modifications been made to facilitate safety based on person's needs i.e. grab bars, ramps, etc. Ask people if they feel safe in the home.		☐	☐
5	People are treated with DIGNITY AND RESPECT	Are people listened to and responded to promptly. Is there interaction between staff and the people who receive services? Are people addressed in their preferred way? Are people extended the same courtesies that anyone would expect? Are personal needs attended to in private? Do people feel they are listened to? Do supports provided emphasize people's capabilities rather than their disabilities or differences? Are people provided meaningful activities and training opportunities? Are people supported to dress, style their hair, the way they prefer?		☐	☐
6	People are supported to learn about their RIGHTS and exercise the rights that are important to them	Ask staff if they are trained to respect people's individual rights. How is knowledge of rights assessed and how rights training is done? Ask people if they know what their rights are and if anyone has ever talked with them about rights. Ask people how their money is handled and whether or not they are satisfied with the process. Do they know how much money they earn or where their funds come from? Do they know where it is kept and how to access it? Are people able to access personal possessions? Do they have a key to their room and the house if they so desire? Observe to see if people move freely		☐	☐

		throughout the home. If there are house rules, were the people involved in the development of them? Are there locks on cabinets, pantries, etc.? Do people have access to money/belongings and a place to secure them? Are people encouraged to advocate for themselves? Are people supported to have choices (bedtimes, mealtimes, activities, etc.)? Do people have opportunity for privacy? Spend time alone if they so desire. Open their own mail? Is information about the person kept confidential? If rights are restricted, is Due Process afforded? Do people attend Human Rights Committee meetings and actively participate in decisions that affect them?			
7	Staff know and implement the procedures for ABUSE and people are supported to know what abuse is and how and to whom to report it	Do staff know what constitutes abuse and how to report? Does training include prevention? Are people who receive services trained on abuse? Ask if people know what abuse is. What would they do if they were abused? Would they know how to report? To whom would they report? Ask staff what happens when abuse occurs? Does the person who is abused receive appropriate follow-up (medical care, counseling, information about the resolution)?		☐	☐
8	Does the provider have a process to determine whether or not people are SATISFIED with services?	Ask staff how they know whether or not the people they work with are satisfied with the services they provide them. What concerns have been expressed? Ask staff and people served to explain the process for expressing a complaint. Ask people if they have had a complaint and what they did about it. Was it resolved in a timely manner and to their satisfaction? Determine if the supports provided are meeting the expectations of the people served.		☐	☐

9	STAFF can describe their roles/ responsibilities in supporting people	What do staff view as their most important responsibility? Do they view themselves as care givers or support providers? Are staff trained to recognize each person as an individual and to promote dignity and respect? Do they support people in achieving personal goals? Do they offer choice in services/supports? Do they understand confidentiality policies and protect consumer information? Ask staff to describe the training are they provided to assist them in performing their roles. Do they feel they are adequately prepared? Determine the staffs' understanding of what to do in the following situations: Medication assistance Health emergencies involving people Infection control Proper positioning Transportation safety		☐	☐

EARLY INTERVENTION INDICATORS & GUIDANCE
Review Year July 2011 through June 2012

The Guidance is provided as a resource to assist agencies with understanding Key Indicators. The Guidance is not intended to be, nor should be, considered as the ultimate resource. It should be, as inferred by its title, a GUIDANCE designed to assist. State and Federal standards including policies and procedures are the ultimate resources for establishing the requirements for an Indicator.

E1	BabyNet Only	Guidance
E1-01	Written Prior Notice and the Child and Family Rights were given to the family prior to six-month update and annual IFSP	Review Service Notes, Family Training Summary Sheet, or a copy of the Written Prior Notice to ensure that the family was given their 7 days Written Prior Notice and was given a copy of the Child and Family Rights. The family may choose to have the meeting sooner than 7 days. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2, & 3
E1-02	Written Prior Notice and the Child and Family Rights were given to the family prior to a change review of the IFSP	Review Service Notes, Family Training Summary Sheet, or a copy of the Written Prior Notice to ensure that the family was given their 7 days Written Prior Notice and was given a copy of the Child and Family Rights. The family may choose to have the meeting sooner than 7 days and this choice will be documented in the service notes or on the summary of service sheets. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2, & 3
E1-03	The Parent/ Caregiver was provided a copy of the Plan	Review service notes to verify that the parent/ caregiver was provided a copy of the Plan. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E1-04 R	**Individualized Family Service Plan (IFSP) is completed annually**	**If not met, document review period dates and date range out of compliance.*** **IFSP must be current within one year. The last page must be signed by the family and the EI.** **Source: IDEA, BabyNet Manual**
E1-05	IFSP six-month review was completed by the end of the sixth month after the IFSP	Ensure the IFSP six-month review was completed by the end of the sixth month following the IFSP. Source: IDEA, BabyNet Manual
E1-06	Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary Form (COSF), if applicable, at entry	If the EI completed the initial IFSP, review the service notes and Child Outcome Summary Form to ensure that the process was completed and documented. Note: If the child is referred at 30 months or younger, the ECO process must be completed. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 8

E1-07	Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary Form (COSF), if applicable, at exit at age three	During the process of a child closing to BabyNet, review the service notes and Child Outcome Summary Form to ensure that the process was completed and documented. Note: If the child received six months or less of services, the ECO exit will not be required. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 8
E1-08	IFSP includes current information relating to vision, hearing, and all areas of development to include health	Review sections 5, 6a, 6b, (& 6c if applicable) of the IFSP to ensure information is current and includes therapy and developmental information. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factor 5
E1-09	All BabyNet services are listed on the Summary of Services page of the IFSP, to include amount, frequency, duration, a begin date and an end date	Review the Summary of Services page of the IFSP to ensure that all BabyNet services being received are listed. (Section 13) Source: BabyNet Manual
E1-10	If the child's IFSP indicates the need for more than 4 hours per month of family training, the service notes indicate that information has been sent to the Office of Children's Services for approval	Review frequency of Family Training as identified on the IFSP. If the frequency noted on the plan is more than 4 hours per month of Family Training there should be documentation indicating that the file was sent to the Office of Children's Services for approval within 15 days of the plan or as identified as a need and this choice will be documented in the service notes or on the summary of service sheets. Source: DDSN EI Manual
E1-11	Transition to other services or settings is coordinated	Review IFSP, Family Training summary sheets and/or Service Notes to ensure that the Early Interventionist completed, or is the process of, any task(s) they were assigned to follow-up on during transitions such as hospital to home, BabyNet to school, home to childcare, have been identified and received follow up. Source: DDSN EI Manual, EI Services Provider Manual, BabyNet Manual
E1-12	The Transition referral is sent to the LEA by the time the child turned 2.6 years old	If the child is 2.6 years or older review Services Notes, transition page of the IFSP, and a copy of the transition referral to ensure the referral was sent by the time the child was 2.6 years old. Source: EI Services Provider Manual, BabyNet Manual
E1-13	Transition Conference was held no later than 90 days prior to the child’s third birthday	Review Service Notes, IFSP, and/or transition page of IFSP to ensure the transition conference was held 90 days prior to the child’s third birthday. The parent /caregiver can choose not to have a conference. Source: EI Services Provider Manual, BabyNet Manual
E1-14	Goals are based on identified needs and the team's concerns relating to the child's development	Compare IFSP sections 6a & 6b to the outcome pages to determine if the Plan indicates who should do what and where it will take place. There should only be one goal per page. Source: EI Services Provider Manual, BabyNet Manual Supports CQL Basic Assurances Factor 8, Shared Values Factors 6, 8, 9

E1-15	Goals are/have been addressed by the Early Interventionist	Review Service Notes and Family Training summary sheets to determine if all outcomes have been or are being addressed by the EI. All developmental goals should be addressed within 3 months of that goal being identified as a need. If the goal(s) are not being addressed, review documentation for supporting information noting why they haven't been addressed. Source: EI Services Provider Manual, BabyNet Manual Supports CQL Shared Values Factor 8
E1-16	Goals are adjusted, terminated or added based on ongoing assessment, lack of progress, or parent / professional request	Review Goal pages, IFSP to ensure that all goals are adjusted, terminated or added based on ongoing assessment, lack of progress, or parent/professional request. Source: EI Services Provider Manual, BabyNet Manual Supports CQL Shared Values Factor 8
E1-17	Assessments are completed every 6 months or as often as changes warrant	Review assessment dates on chosen assessment tool(s) and IFSP to ensure they are completed every 6 months or as changes warrant (i.e., significant improvement or regression). Note: Applies to Assessments completed as of 2/1/11 Source: EI Services Provider Manual, BabyNet Manual Supports CQL Shared Values Factor 8
E1-18	Family Training is provided as documented on the IFSP Summary of Services page	The IFSP should outline the frequency of Family Training. Review the ISRs, Family Training summary sheets, IFSP Summary of Services section, to ensure that FT is provided at the frequency and duration outlined. If the frequency and duration outlined is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. Source: EI Services Provider Manual, BabyNet Manual
E1-19	Family Training summary sheets include goals and objectives for each visit as well as follow-up objectives for the next visit	Family Training summary sheets should indicate the scheduled time and date of the next visit and what the caregiver will work on with the child until the next training visit. Review Family training summary sheets to ensure that they include goals and objectives for each visit and what the caregiver will work on until the next training visit with an error rate of no more than 2 mistakes during the review period. Source: DDSN EI Manual
E1-20	Family training activities are appropriate for the child's developmental needs	Review EI assessment tool(s), therapy reports, provider reports, IFSP and IFSP goals and compare information on these documents to the Family Training summary sheets. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factors 8, & 9
E1-21 W	Entries for Family training visits include how family member(s)/caregiver(s) participated in visit	Review Family Training summary sheets and Service Notes to ensure that family/caregiver participated in training sessions. To state that the parent/caregiver was present is NOT sufficient. The summary of visit should include how the parent/caregiver actively participated in the visit. Review Family training summary sheets to ensure that they include this information. Source: DDSN EI Manual, EI Services Provider Manual

E1-22	Family Training activities should vary. Activities planned must be based on identified goals on the IFSP	Review the Family Training summary sheets to ensure that the activities vary in order to meet the goals for the child. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factors 3, 8, & 9
E1-23	Family Training activities correspond to goals on the IFSP goal pages	If not met, document review period dates and date range out of compliance.* Review goals on the IFSP goal pages (Section 10a) and Family Training Summary sheets. Compare goals with Family Training activities. Source: DDSN EI Manual, EI Services Provider Manual
E1-24	Time spent/reported preparing for a Family Training visit corresponds with the activity planned	Review Service Notes and Family Training Summary Sheets to determine if the time reported for preparing for a Family Training visit corresponds to the activities completed during the visit. For example, an EI should not report 15 minutes of "prep time" for a visit if when the EI got to the home they worked on singing songs or putting puzzles together. Source: DDSN EI Manual
E1-25	If the Early Interventionist is unable to provide Family Training for an extended period of time (more than a month) was the family offered a choice of an alternate Early Interventionist	Review the Service Justification Form, service notes, and/or Family Training Summary Sheets to ensure the family was offered an alternate Early Interventionist to provide Family Training. Source: IDEA, BabyNet Manual, DDSN EI Manual
E1-26	Entries are clear and are documented within 7 days of services being rendered	Review Service Notes to ensure clarity and inclusion of name/initials of Early Interventionist. All services must be documented in the file within seven days of delivery. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E1-27	All items in the record are maintained in chronological order in respective sections	Review records from all program areas that the person is involved with to determine if documents located in the respective sections of the record are maintained in chronological order. Source: DDSN EI Manual, EI Services Provider Manual, BabyNet Manual
E1-28	Service Note entries reference the appropriate Family Training summary sheet	Review Service Notes to ensure dates match dates on Family Training summary sheets. Source: DDSN EI Manual, EI Services Provider Manual
E1-29	Service Notes document why and how the Early Interventionist participated in meetings / appointments on the child's behalf	Review Service Notes to ensure why and how the Early Interventionist participated in the meeting/appointment. The Early Interventionist must justify why they are reporting the time that they are at the meeting/appointment. For example, it would not be appropriate for an EI to attend a Developmental Pediatrician's appointment and then report time for attending the entire appointment. It is appropriate to report time for when the EI was actively participating in the visit. Source: DDSN EI Manual

E1-30	ISRs are present and reflect services rendered correctly	Review ISRs, Service Notes and Family Training Summary Sheets to compare documentation with reporting on ISRs. Source: DDSN EI Manual
E1-31	If applicable, documentation in service notes indicates that the case was closed	Review service notes of a closed file to determine if it was documented that the case was being closed.
E1-32 Not included in score	Did the child receive more than 2 hours of Service Coordination in any calendar month? (except for the months in which an initial plan, annual plan, or transition conference were held)	During the review period, except for the months in which an initial plan, annual plan, or transition conference were held, did the child receive more than 2 hours of Service Coordination in any calendar month? If so, document the month(s) and total amount of time for the month. For example: April 2011, 2:23; June 2011, 3:35. Note: For Informational purposes only. Does not affect the score.

E2	BabyNet / DDSN	Guidance: Review all Plans (IFSP/FSP) in effect for the period in review
E2-01	Service Agreement signed and present in file once a need for a DDSN service has been identified	Review DDSN Service Agreement in file. Source: DDSN EI Manual
E2-02	Intake process is completed within required time frames. (For New Consumers Only)	If not met, document review period dates and date range out of compliance. Review the date family was offered a choice of provider during the screening process (see Screening Disposition Form) and date eligibility was determined to see if intake has been completed within 3 months. If eligibility is not completed in 3 months, case must be staffed with the Early Intervention Supervisor as to a reason for delay and action taken to address the delay, if applicable. If not documented in 6 months, case must be staffed with the Executive Director, and the decision of closing the case must be documented in the service notes. Extensions in both circumstances require documentation in service notes. Source: DDSN EI Manual
E2-03	Transition to other services or settings is coordinated	Review IFSP/FSP Family Training Summary Sheets and/or Service Notes to ensure that the Early Interventionist completed, or is the process of completing, any task(s) they were assigned to follow-up on during transitions. Examples of these transitions could include hospital to home, BabyNet to school, home to childcare, etc. Source: IDEA, DDSN EI Manual, EI Services Provider Manual, BabyNet Manual
E2-04	Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary Form (COSF), if applicable, at entry	If the EI completed the initial IFSP/FSP, review the service notes and Child Outcome Summary Form to ensure that the process was completed and documented. Note: If the child is referred at 30 months or younger, the ECO process must be completed. Source: IDEA, BabyNet Manual
E2-05	Early Childhood Outcomes (ECO) were assessed and documented on the Child Outcome Summary Form (COSF), if applicable, at exit at age three	During the process of a child closing to BabyNet, review the service notes and Child Outcome Summary Form to ensure that the process was completed and documented. Note: If the child received six months or less of services, the ECO exit will not be required. Source: IDEA, BabyNet Manual
E2-06 R	**Individualized Family Service Plan (IFSP/FSP) is completed annually**	**IFSP/FSP must be current within one year. The last page must be signed by the family and the EI.** **Source: IDEA, EI Services Provider Manual, BabyNet Manual**
E2-07	The Parent/ Caregiver was provided a copy of the Plan	Review service notes to verify that the parent/ caregiver was provided a copy of the Plan. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E2-08	IFSP/FSP six-month review was completed by the end of the sixth month after the IFSP/FSP	Ensure the IFSP/FSP six-month review was completed by the end of the sixth month following the IFSP/FSP. Source: IDEA, BabyNet Manual

E2-09	Written Prior Notice and Child and Family Rights were given to the family prior to the six-month review of the IFSP and the annual IFSP	Review service notes, Family Training Summary Sheets, or a copy of the Written Prior Notice to ensure that the family was given at least 7 days written prior notice and was given a copy of the Child and Family Rights. The family may choose to have the meeting sooner than 7 days and this choice will be documented in the service notes or on the summary of service sheets. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2, & 3
E2-10	Written Prior Notice and the Child and Family Rights were given to the family prior to a change review of the IFSP	Review Service Notes, Family Training Summary Sheet, or a copy of the Written Prior Notice to ensure that the family was given their 7 days Written Prior Notice and was given a copy of the Child and Family Rights. The family may choose to have the meeting sooner than 7 days and this choice will be documented in the service notes or on the summary of service sheets. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factors 1 & 2, Shared Values Factors 1, 2, & 3
E2-11	The Choice of Early Intervention Provider is offered annually	Review services notes, Family Training Summary Sheets, and the Acknowledgment of SC/EI choice form to ensure the family has been given a choice of providers and the choice is documented. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3
E2-12	IFSP/FSP includes current information relating to vision, hearing, medical, therapy, and all areas of development to include health	Review sections 5, 5b, 6b, (& 6c if applicable) of the IFSP/FSP to ensure information is current and includes therapy and developmental information. Source: IDEA, BabyNet Manual Supports CQL Basic Assurances Factor 5
E2-13	Goals are based on identified needs and the team's concerns relating to the child's development	Compare IFSP/FSP sections 5, 5b, 6b, (& 6c if applicable) to the goal pages to determine if the IFSP/FSP indicates who should do what and where it will take place. There should only be one goal per page. Source: BabyNet Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 6, 8, & 9
E2-14	Goals are/have been addressed by the Early Interventionist	Review Service Notes and Family Training summary sheets to determine if all outcomes have been or are being addressed by the EI. All developmental goals should be addressed within 3 months of that goal being identified as a need. If the goal(s) are not being addressed, review documentation for supporting information noting why they haven't been addressed. Source: EI Services Provider Manual, BabyNet Manual Supports CQL Shared Values Factor 8
E2-15	Goals are adjusted, terminated or added based on ongoing assessment, lack of progress, or parent / professional request	Review goal pages of the IFSP/FSP to ensure that all goals are terminated, adjusted or added based on ongoing assessment, lack of progress, or parent/professional request. Source: BabyNet Manual Supports CQL Shared Values Factor 8

E2-16	The transition referral is sent to the LEA by the time the child turns 2.6 years old	If the child is 2.6 years old or older, review service notes, transition page of the IFSP/FSP and a copy of the transition referral to ensure the referral was sent by the time the child was 2.6 years old. Source: IDEA, BabyNet Manual
E2-17	Transition conference was held no later than 90 days prior to the child's third birthday	Review services notes, Family Training Summary Sheets, transition page of the IFSP/FSP or transition conference form to ensure the transition conference was held 90 days prior to the child's third birthday. The parent/caregiver can chose to not have a conference. Source: IDEA, BabyNet Manual, EI Services Provider Manual
E2-18	FSP "Other Services" section reflects the amount, frequency & duration of services being received. This section should reflect non BabyNet services (Waiver, Family Support Funds, Respite, ABC, etc)	Review FSP in effect during period in review to ensure the amount, frequency & duration of current services is included. Source: IDEA, BabyNet Manual
E2-19	All BabyNet services are listed on the Summary of Services page of the IFSP to include amount, frequency, duration, a begin date and an end date	Review the Summary of Service page of the IFSP to ensure that all BabyNet services being received are listed. Source: BabyNet Manual
E2-20	If the child's IFSP/FSP indicates the need for more than 4 hours per month of Family Training, the service notes indicate that information has been sent to the Office of Children's Services for approval	Review frequency of Family Training as identified on the IFSP/FSP. If the frequency noted on the IFSP/FSP is more than 4 hours per month of Family Training there should be documentation indicating that the file was sent to the Office of Children's Services for review. Source: DDSN EI Manual
E2-21	Assessments are completed every 6 months or as often as changes warrant	Review assessment dates on chosen assessment tool(s) and IFSP/FSP to ensure they are completed every 6 months, or as changes warrant (i.e., significant improvement or regression). Note: Applies to Assessments completed as of 2/1/11 Source: BabyNet Manual, EI Services Provider Manual Supports CQL Shared Values Factor 8
E2-22	Family Training activities correspond to outcomes on the IFSP/FSP goal pages	Review the record to determine if standards, policies and procedures are followed during the IFSP/FSP process. Source: DDSN EI Manual

E2-23 W	Family Training is provided according to the frequency determined by the team and as documented in the Summary of Services section of the IFSP/FSP	The IFSP/FSP should outline the frequency and duration of Family Training. Review the ISRs, Family Training summary sheets, IFSP/FSP Summary of Services section to ensure that Family Training is provided at the frequency and duration outlined. If the frequency and duration outlined is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. Review Family Training summary sheets and service notes to ensure that they include this information. Source: BabyNet Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 8, & 9
E2-24	Family Training summary sheets include goals and objectives for each visit as well as follow-up objectives for the next visit	Family Training summary sheets should indicate the scheduled time and date of the next visit and what the caregiver will work on with the child until the next training visit. Review Family Training summary sheets to ensure that they include goals and objectives for each visit as well as objectives for the next visit with an error rate of no more than 2 mistakes during the review period. Source: DDSN EI Manual
E2-25	Family Training activities are appropriate for the child's developmental needs	Review EI assessment tool(s), therapy, provider reports and IFSP/FSP and compare to Family Training summary sheets. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 8, & 9
E2-26 W	Entries for Family Training visits include how family member(s)/ caregiver(s) participated in visit	Review Family Training summary sheets and Service Notes to ensure that family/caregiver participated in training sessions. To state that the parent/caregiver was present is NOT sufficient. The summary of visit should include how the parent/caregiver actively participated in the visit. Review Family Training summary sheets to ensure that they include this information. Source: DDSN EI Manual
E2-27	Family Training activities should vary	Review the Family Training summary sheets to ensure that the activities vary in order to meet the outcomes for the child. Source: DDSN EI Manual
E2-28	Family Training activities correspond to goals on the IFSP/FSP goal pages	Review goals on the IFSP/FSP goal pages (section 10a) and Family Training summary sheets. Compare goals with Family Training activities. Source: DDSN EI Manual
E2-29	Time spent/reported preparing for a Family Training visit corresponds with the activity in the IFSP/FSP	Review Service Notes and data sheets to determine if the time reported for preparing for a Family Training visit corresponds to the activities completed during the visit. For example, an EI should not report 15 minutes of "prep time" for a visit if when the EI got to the home they worked on singing songs or putting puzzles together. Source: DDSN EI Manual

E2-30	If the Early Interventionist is unable to provide Family Training for an extended period of time (more than a month) was the family offered a choice of an alternate Early Interventionist	Review the Service Justification Form, service notes, and/or Family Training Summary Sheets to ensure the family was offered an alternate Early Interventionist to provide Family Training. Source: IDEA, BabyNet Manual, DDSN EI Manual
E2-31	Entries are clear and are documented within 7 business days of services being rendered	Review Service Notes to ensure clarity and inclusion of name/initials of the Early Interventionist. All services must be documented in the file within seven days of delivery. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E2-32	All items in the record are maintained in chronological order in the respective sections	Review records from all program areas that the person is involved with to determine if documents located in the respective sections of the record and are maintained in chronological order. Source: IDEA, BabyNet Manual, DDSN EI Manual
E2-33	Service note entries reference the appropriate Family Training summary sheet	Review Service Notes to ensure dates match dates on Family Training summary sheets. Source: DDSN EI Manual, EI Services Provider Manual
E2-34	Service notes document why and how the Early Interventionist participated in meetings/appointments on the child's behalf	Review Service Notes to ensure why and how the Early Interventionist participated in the meeting/appointment. The Early Interventionist must justify why they are reporting the time that they are at the meeting/appointment. For example, it would not be appropriate for an EI to attend a Developmental Pediatrician's appointment and then report time for attending the entire appointment. Source: DDSN EI Manual
E2-35	ISRs are present and reflect services rendered correctly	Review ISRs, Service Notes and Family Training Summary Sheets to compare documentation with reporting on ISRs. Source: DDSN EI Manual, EI Services Provider Manual
E2-36	If applicable, documentation in service notes indicates that the case was closed	Review service notes of a closed file to determine if it was documented that the case was being closed.
E2-37 Not included in score	Did the child receive more than 2 hours of Service Coordination in any calendar month? (except for the months in which an initial plan, annual plan, or transition conference were held)	During the review period, except for the months in which an initial plan, annual plan, or transition conference were held, did the child receive more than 2 hours of Service Coordination in any calendar month? If so, document the month(s) and total amount of time for the month. For example: April 2011, 2:23; June 2011, 3:35. Note: For Informational purposes only. Does not affect the score.

E2	BabyNet/DDSN MR/RD Waiver	Guidance: Review all Plans (IFSP/FSP) in effect for the period in review
E2-38	The content of the IFSP/FSP clearly justifies the need for MR/RD Waiver services	Review the IFSP/FSP to ensure that the MR/RD Waiver services being authorized are justified according to the MR/RD waiver service definitions. Source: MR/RD Waiver Manual
E2-39 R	**The IFSP/FSP includes MR/RD Waiver service/s name/s, frequency of the service/s, amount of service/s, duration of service and valid provider type for service/s**	**For each Waiver service received by the participant, the IFSP/FSP must document the need for the service, the correct waiver service name, the amount, frequency, duration and the provider type [refer to the MR/RD Waiver Document for provider types (Chapter 2 of MR Waiver Manual)].** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" or, "per week" or "weekly" as applicable).** **Note: Regarding "duration" check only that a duration is specified.** **Source: MR/RD Waiver Manual**
E2-40	The Freedom of Choice Form is present	Review the record of those enrolled or re-enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). Note: :Look at only those enrolled or re-enrolled Source: MR/RD Waiver Manual
E2-41 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Early Interventionist for all individuals except for those whose eligibility determination is "Time-limited", or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Note: Look at only timeframes and who completed it.** **Source: MR/RD Waiver Manual**
E2-42	The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination	Review the most current LOC determination and compare it to information in assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment. Note: Look only at lines on the LOC Assessment Source: MR/RD Waiver Manual

E2-43 R	**The current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete with appropriate responses.** **Note: Ensure that all areas are complete or checked.** **Source: MR/RD Waiver Manual**
E2-44	Documentation is present verifying that a choice of providers was offered to the participant/family for each new MR/RD Waiver Service	Review the Service Notes, IFSP/FSP, and Family Training Summary Sheets to determine if the parent/legal guardian (if applicable) was given a choice of provider of service each time a new service need was identified/authorized. Source: MR/RD Waiver Manual
E2-45	The Acknowledgment of Rights and Responsibilities (MR/RD Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by the participant/legal guardian, if applicable) on the current and previous forms to ensure they have been completely annually (within 12 months of the previous form). Source: MR/RD Waiver Manual
E2-46	MR/RD Waiver services are provided in accordance with the service definitions found in the waiver document	Review service definitions in the MR/RD Waiver documents (chapter 2 of the MR/RD Waiver Manual) for each service that the participant is receiving. Review IFSP/FSP, service notes, relevant service assessments and FTSS to ensure that services are being provided according to the definitions. Source: MR/RD Waiver Manual
E2-47	MR/RD Waiver services are received at least every 30 calendar days	Review Services Notes, IFSP/FSP, and Family Training Summary Sheets to ensure that the participant has received or is receiving at least one Waiver service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 calendar days, the participant should have been disenrolled from the MR/RD Waiver. Note: Children's PCA and Private Duty Nursing do not count, as they are State Plan Medicaid Services Source: MR/RD Waiver Manual
E2-48	Service needs outside the scope of Waiver services are identified in IFSP/FSP and addressed	Review IFSP/FSP, Service Notes, and Family Training Summary Sheets to ensure that EI has identified and addressed all service needs regardless of the funding source. Source: MR/RD Waiver Manual
E2-49	Authorization forms are properly completed for services, as required, prior to service provision	Review the participant's IFSP/FSP and ensure that authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Early Interventionist's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS-enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. Source: MR/RD Waiver Manual

E2-50	Service notes reflect monitorship within the first month of the start of an ongoing MR/RD Waiver service or provider change	Review Service Notes, IFSP/FSP and service authorizations to determine if the participant began receiving a new ongoing service and/or changed providers of a previously received ongoing service during the review period. If so, review Service Notes, Family Training Summary Sheets and IFSP/FSP to determine if the service was monitored within one month after the start date or provider change. Source: MR/RD Waiver Manual
E2-51	Service notes reflect monitorship within the second month from the start of an ongoing MR/RD Waiver service or provider change	Review Service Notes, IFSP/FSP and service authorizations to determine if the participant began receiving a new ongoing service and/or changed providers of a previously received ongoing service during the review period. If so, review Service Notes, Family Training Summary Sheets and IFSP/FSP to determine if the service was monitored within the second month after the start date or provider change. Source: MR/RD Waiver Manual
E2-52	Service Notes reflect monitorship with the recipient within 2 weeks of a one-time service and reflect that the service was received	Review Service Notes, IFSP/FSP and Family Training Summary Sheets and service authorizations to determine if the participant received any one-time services during the review period. If so, review the service notes to determine if the service was monitored within 2 weeks of receipt to determine if the participant received the service. Source: MR/RD Waiver Manual
E2-53	Services Notes reflect on-site monitorship of Environmental Modifications within 2 weeks of completion	Review Service Notes, IFSP/FSP and Family Training Summary Sheets and service authorizations to determine if an environmental modification was completed during the review period. If so, review the Service Notes to determine if the modification was seen by the EI within 2 weeks of the completion date. Source: MR/RD Waiver Manual
E2-54	Service notes reflect an on-site monitorship of Private Vehicle Modifications within 2 weeks of completion	Review Service Notes, IFSP/FSP and Family Training Summary Sheets and Service Authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the EI within 2 weeks of the completion date. Source: MR/RD Waiver Manual
E2-55	For any one-time Assistive Technology item costing over $2500.00, the Early Interventionist has made an on-site visit to observe the item	Review Service Notes, IFSP/FSP and Family Training Summary Sheets and Service Authorizations to determine if any assistive technology item costing over $2500.00 was provided during the review period. If so, review the Service Notes to determine if the item was seen in the recipient's possession by the EI. Source: MR/RD Waiver Manual

E2-56	The Participant/Legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of MR/RD Waiver services with accompanying reconsideration/appeals information	Review Services Notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the participant/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate reconsideration/appeals process. Note: If the participant/legal guardian (if applicable) *requested* to terminate, suspend, or reduce the service, this Indicator is N/A MR/RD Waiver Manual

E2	BabyNet/DDSN HASCI Waiver	Guidance: Review all Plans (IFSP/FSP) in effect for the period in review
E2-57	The content of the IFSP/FSP clearly justifies the need for Waiver services	Review the IFSP/FSP to ensure that the Waiver services being authorized are justified in the content of the IFSP/FSP. Source: HASCI Waiver Manual
E2-58 R	**The IFSP/FSP includes HASCI Waiver service/s name, frequency of the service/s, amount of service/s, duration of service/s and provider type for service/s**	**For each waiver service received by the person, the plan must document the need for the service; the correct waiver service name/ acceptable substitute as listed in the Waiver manual, the amount, frequency and duration of the service and the provider type (refer to the HASCI Waiver Document for provider types).** **Source: HASCI Waiver Manual**
E2-59	The Freedom of Choice Form is present	Review the record of those enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver person or his/her legal guardian (if applicable). Source: HASCI Waiver Manual
E2-60	The Initial Level of Care is present	Review the initial LOC determination to determine if it was completed prior to or on the date of Waiver enrollment. For ICF/MR Level of care, the initial Level of Care date is the "effective date" on the Certification Letter (ICF/MR Level of Care). For NF Level of Care, the initial Level of Care date is the date on the CLTC transmittal form (NF Level of Care, HASCI Form 7). NOTE: A person must be enrolled in the Waiver within 30 days of the initial Level of Care (LOC) determination. NOTE: If the person is enrolled in the Waiver within 30 days of the initial LOC determination the LOC effective date is valid for 365 days from the initial LOC date. Source: HASCI Waiver Manual
E2-61 R	**The most current Recertification is dated within 365 days of the last Recertification**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days and ensure all sections of the LOC Determination are complete. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Service Coordinators for all consumers except for those persons whose eligibility determination is "Time-Limited", or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Source: HASCI Waiver Manual**

E2-62	The current Level of Care is supported by the current IFSP/FSP and supporting assessments indicated on the LOC Determination	Review the most current LOC determination (either a Nursing Facility Level of Care or an ICF/MR Level of Care is completed) and compare it to information in the current IFSP/FSP and other assessments referenced as sources for the LOC evaluation to determine if documentation supports the current Level of Care assessment. If the ICF/MR Level of Care is completed, the supporting assessments used to make the determination will be listed on the ICF/MR LOC determination and summarized in the. If the Nursing Facility Level of Care is completed, the results of the determination will be summarized in the IFSP/FSP.
E2-63	On IFSP/FSP documents where the person refused a Waiver service(s), the risks associated with refusing the service(s) were addressed	Review service notes and other record documentation along with all IFSP/FSP are completed during the review period to determine if a person participating in the Waiver refused a HASCI Waiver service. If a service was refused, review the record to locate documentation that the risks associated with refusing the service were addressed. Source: HASCI Waiver Manual
E2-64	Records verify that evaluations / reevaluations were completed in accordance with procedures specified in the approved Waiver	For ICF/MR Level of Care, initial evaluations are requested from SCDDSN's Consumer Assessment Team. The EI must submit a packet of information to the team to determine LOC. Re-evaluations are completed by Early Interventionists for all consumers except for those persons whose eligibility determination is "time-limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these re-evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. For ICF/MR Level of Care Re-evaluations, the date the Level of Care Re-evaluation is completed, is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 and expiration date of 7/2/09.For NF Level of Care, Community Long Term Care (CLTC) conducts initial evaluations. The EI is responsible for obtaining consent from the potential Waiver person and forwarding the consent and transmittal to CLTC. DDSN Early Intervention staff completes re-evaluations. For NF Level of Care re-evaluations, service notes must reflect that the reevaluation occurred on a home visit with the Waiver person and the reevaluation was staffed with the Early Intervention Supervisor or other responsible party within 2 working days of the home visit as verified by initial and date of the supervisor on DHHS Form 1718. The staffing date is the NF LOC date. Source: HASCI Waiver Manual
E2-65	If the person was disenrolled / terminated from the Waiver, the Termination (HASCI Form 8) was completed within 2 working days of the disenrollment date	Review the service notes, the IFSP/FSP and Termination form to ensure that the EI completed the form within 2 working days of notification that the Waiver person needed to be disenrolled. Source: HASCI Waiver Manual

E2-66	Documentation is present verifying that a choice of providers was offered to the person/family for each new HASCI Waiver Service	Review the service notes and the person's Plan to determine if the person or guardian was given a choice of provider of service. Source: HASCI Waiver Manual
E2-67 W	The Acknowledgement of Choice and Appeal Rights is completed prior to Waiver enrollment and on an annual basis	Review the record to ensure that the Acknowledgement of Choice and Appeal Rights (HASCI Form 19) is present. Review signature dates on the forms to ensure they were completed prior to Waiver enrollment and on an annual basis. Source: HASCI Waiver Manual
E2-68	The Acknowledgement of Rights and Responsibilities is present	Review the record to ensure that the Acknowledgement of Rights and Responsibilities (HASCI Form 20) is present. This must be completed "one-time" at the Plan meeting. For new Waiver persons it must be completed prior to Waiver enrollment. It is not required annually. Persons will not have this form on record prior to December 2004 Score "Met" in this case. Source: HASCI Waiver Manual
E2-69	Waiver services are provided according to provisions in the service definitions in the Waiver document	Review service definitions in the Waiver documents for each service that the person is receiving. Review the person's IFSP/FSP and Service Notes to ensure that services are being provided according to the definitions. Source: HASCI Waiver Manual
E2-70	If Nursing Services are provided, an order from the physician is present and coordinates with the Authorization of Services Form (HASCI Form 12-D)	Review record to ensure that a doctor's order is available and is consistent with the amount and type of Nursing Services authorized for the person. Source: HASCI Waiver Manual
E2-71	HASCI Waiver services are received at least every 30 days	Review services notes, the IFSP/FSP, and IFSP/FSP Amendments to ensure that the person has received or is receiving at least one Waiver service each month during the review period. A service must be received during each calendar month. If at least one service was not received each month, the person should have been disenrolled from the Waiver. For example, if a Waiver participant receives a Waiver service on March 17th and receives no other Waiver services before April 30th, then the Waiver participant would be disenrolled from the Waiver. Source: HASCI Waiver Manual
E2-72	Service needs and personal goals outside the scope of Waiver services are identified in IFSP/FSP documents and addressed	Review the IFSP/FSP documents, Service Notes, and other documentation in the record to ensure that the EI has identified and addressed all service needs and personal goals for the person, regardless of the funding source. Source: HASCI Waiver Manual

E2-73	Authorization forms are completed for services, as required, prior to service provision	Authorization for Services forms are present and note a "start date" for services that should be the same or after the date of the EI's signature. Authorization forms are required for all services except Prescribed Drugs. Source: HASCI Waiver Manual
E2-74	The established Waiver documentation index is followed	Review the Waiver information in the record and compare it to the established Waiver documentation index. Source: HASCI Waiver Manual
E2-75	Service Notes reflect contact within 2 weeks of the start of an ongoing service or provider change and include the usefulness, effectiveness, frequency, duration and the person/family's satisfaction with the service	Review service notes, the IFSP/FSP and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service. If so, review Service Notes and other documentation in the record to determine if service or provider change was monitored within 2 weeks and documentation regarding include the usefulness, effectiveness, frequency, duration and the person/family's satisfaction with the service is present. Source: HASCI Waiver Manual
E2-76 W	One-Time Services: Service Notes reflect contact with the person within 2 weeks of the service and reflect that the service was received	Review Service Notes, the IFSP/FSP and service authorizations to determine if the person received any one-time services during the review period. If so, review the Contact Notes to determine if the service was monitored within 2 weeks to determine if the person received the service and provides a statement of usefulness, effectiveness, and benefit of the service and person's/family's satisfaction with the service. Source: HASCI Waiver Manual
E2-77	Service Notes reflect an on-site visit for Environmental Modifications within 2 weeks of completion	Review service notes, the IFSP/FSP and service authorizations to determine if an Environmental Modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the EI within 2 weeks of the completion date. Also review documentation to ensure support of the usefulness and effectiveness of the service along with the person's/family's satisfaction with the service. Source: HASCI Waiver Manual

E2-78	Service notes reflect an on-site visit for Private Vehicle Modifications within 2 weeks of completion	Review service notes, the IFSP/FSP and Service Authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Early Interventionist within 2 weeks of the completion date and documentation is available to support the usefulness and effectiveness of the service along with the person's/family's satisfaction with the service. Source: HASCI Waiver Manual
E2-79	For any one-time service that costs $1500.00 or more, the Early Interventionist has made an on-site visit to observe the item and to document the item's usefulness and effectiveness	Review service notes, the IFSP/FSP and Service Authorizations to determine if any one-time service costing over $1500.00 was provided during the review period. If so, review the service notes to determine if the item was monitored on-site by the EI and documentation is available to support the usefulness, effectiveness, and benefit of the service along with the person's/family's satisfaction with the service. Source: HASCI Waiver Manual
E2-80	For all services provided by the Board (also called Board-Based services), documentation is available to show the service was provided on date service was reported	Respite Care: Documentation is present to reflect that service was provided by a qualified provider. Refer to Appendix B-2 and Attachment 1 of the Waiver document. The IFSP/FSP reflects need for the service. The "Individual Summary of Board Based Services Provided" reflects the amount of Respite Care provided. NOTE: Not needed, if direct billed. Data/documentation is available to show services were provided on the date services were reported. Attendant Care/Personal Assistance Services: Documentation is present to reflect that services were provided by a qualified provider. Refer to Waiver Funded Home Support Caregiver certification and Appendix B-2 and Attachment 37 of the Waiver document. Individual summary of Board-based services provided is present and reflects the amount of service provided. NOTE: not needed if direct-billed. The IFSP/FSP reflects need for the service and amount of supervision required. Data/documentation is present to reflect services provided (daily time sheets noting tasks completed) on the date service was reported. Data/documentation is present to reflect supervision of the attendant by a nurse. For nursing services, look for data/documentation to reflect that the service was provided by a RN or LPN on the date the service was reported. Individual Summary of Board Based Services provided is present and reflect the amount of services provided. The IFSP/FSP reflects the need for the service as ordered by the physician. NOTE: Not needed, if direct billed. Psychological Services: Documentation is present to reflect that service was provided by a qualified provider. Refer to Appendix B-2 and Attachment 8 of the Waiver document. Individual Summary of Board Based Services provided is present and reflects the amount of services provided. NOTE: Not needed, if direct billed. The IFSP/FSP reflects need for the service. Data/documentation is present reflecting service provided (invoices, progress notes, etc.) on the date service was reported.

		Behavioral Support Services: New HASCI Waiver service effective 7/1/05. Documentation is present to reflect that service was provided by a qualified provider. Refer to Appendix B-2 and Attachment 9 of the Waiver document. Individual Summary of Board Based Services provided is present and reflects the amount of services provided. NOTE: Not needed, if direct billed. For Private Vehicle Modifications, look for a copy of the certificate or service note that shows the installer reports that he/she has been certified in the installation and repair of the manufacturer's equipment. For private vehicle assessments, installation, follow-up inspection and training in the use of the private vehicle modifications refer to Appendix B-2, Attachment 10 of the HASCI Waiver document for qualified providers. For Environmental Modifications, a licensed contractor must be used. Look for the license number issued by the SC Labor Licensing and Regulation (SCLLR). The IFSP/FSP must reflect the need for the service and general description of the work to be completed. Look for a copy of the invoice for the work with person's name and notation that the work is complete. NOTE: An automatic door system or grab bars may be installed by a licensed contractor or a vendor with a retail or wholesale business license contracted to provide the service(s); for ex., a Durable Medical Equipment vendor. NOTE: All adaptations/modifications to the home that require building any type for example, using hammer and nails must be done by contractors that are licensed by the State of South Carolina through the SC Department of Labor, Licensing and Regulation, Contractor's Licensing Board. Source: HASCI Waiver Manual
E2-81	Documentation is present verifying that a provider is being actively sought when a provider is unavailable for any Waiver Service	Review the service notes and the person's IFSP/FSP to determine if the Early Interventionist is actively seeking a provider of a Waiver service when a provider has not been found to provide the service. Source: HASCI Waiver Manual.
E2-82	Nurse supervisory reports are present for attendant care services and the IFSP/FSP includes the need, frequency and intensity of the supervision	Review the IFSP/FSP to assure it includes the need for supervision or a statement that the person or responsible party is able to direct his/her care (this information may be included in the Background Document of the IFSP/FSP). Review the Waiver Services Summary Page of the IFSP/FSP to assure that it includes the frequency and intensity of the nurse supervision of attendant care services. Review nurse (LPN or RN licensed to practice in the state) supervisory progress reports. Nurse supervisory reports must be received and reviewed by the Service Coordinator. Nurse supervisory reports are required from the nursing provider at least every 120 days unless there is a statement that the person or responsible party is able to direct his/her own care. Look for a copy of the nurse's license in the file or review contact notes documenting the license # of the nurse. NOTE: Nursing providers may complete supervisory reports every 90 days (depends on the provider), however, at least every 120 days is required. Source: HASCI Waiver Manual

E2-83	Waiver Tracking System is consistent with records regarding services and the IFSP/FSP includes and justifies the need for all HASCI Waiver services	Review the Waiver services listed in the IFSP/FSP and IFSP/FSP amendments and compare them with the services listed on the Waiver tracking system. Also review the service authorizations and Medicaid Paid Claims to ensure that all Wavier Services are included and supported in the person's IFSP/FSP. NOTE: Service names on the Waiver tracking system are different from accurate Waiver service names. Source: HASCI Waiver Manual
E2-84	The Legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of Waiver services with accompanying appeals information	Review service notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate appeals process. Source: HASCI Waiver Manual

E2	Community Supports Waiver	Guidance
E2-85	The content of the IFSP/FSP clearly justifies the need for COMMUNITY SUPPORTS Waiver services	Review the IFSP/FSP to ensure that the COMMUNITY SUPPORTS Waiver services being authorized are justified in the content of the IFSP/FSP according to the Community Supports Waiver service definitions. Source: COMMUNITY SUPPORTS Waiver Manual
E2-86 R	**The IFSP/FSP includes COMMUNITY SUPPORTS Waiver service/s name/s, frequency of the service/s, amount of service/s, duration and provider type for service/s**	**For each waiver service received by the person, the plan must document the need for the service, the correct waiver service name, the amount, frequency, duration and the provider type (refer to the COMMUNITY SUPPORTS Waiver Document for provider types/Chapter 2, CSW Manual)** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" or, "per week" or "weekly").** **Note: Regarding "duration" check only that a duration is specified.** **Source: COMMUNITY SUPPORTS Waiver Manual**
E2-87	The Freedom of Choice Form is present	Review the record of those enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). Source: COMMUNITY SUPPORTS Waiver Manual
E2-88 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Early Interventionist for all individuals except for those whose eligibility determination is "Time-limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Note: Look at only timeframes and who completed it.** **Source: COMMUNITY SUPPORTS Waiver Manual**
E2-89	The current Level of Care is supported by the assessments and documents indicated on the Level of Care Determination	Review the most current LOC determination and compare it to information in assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment. Note: Look at only lines on LOC Assessment Source: COMMUNITY SUPPORTS Waiver Manual

E2-90 R	**The current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete.** **Note: Ensure that all areas are complete with appropriate responses.** **Source: COMMUNITY SUPPORTS Waiver Manual**
E2-91	Documentation is present verifying that a choice of providers was offered to the person / family for each new COMMUNITY SUPPORTS Waiver Service	Review the Service Notes, IFSP/FSP and Family Training Summary Sheets to determine if the parent/legal guardian (if applicable) was given a choice of provider each time a new service need was identified/authorized. Source: COMMUNITY SUPPORTS Waiver Manual
E2-92	The Acknowledgement of Rights and Responsibilities (COMMUNITY SUPPORTS Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by the person/legal guardian, if applicable) on the current and previous forms to ensure they have been completed annually (within 12 months of the previous form). Source: COMMUNITY SUPPORTS Waiver Manual
E2-93	COMMUNITY SUPPORTS Waiver Services are provided in accordance with the service definitions	Review Service definitions in the COMMUNITY SUPPORTS Waiver document for each service the person is receiving. Review IFSP/FSP, Service Notes, relevant service assessments and Family Training Summary Sheets to ensure that services are being provided according to the definitions. Source: COMMUNITY SUPPORTS Waiver Manual
E2-94	COMMUNITY SUPPORTS Waiver Services are received at least every 30 calendar days	Review Service Notes, IFSP/FSP, and Family Training Summary Sheets to ensure that the person has received or is receiving at least one Waiver Service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 calendar days, the person should have been disenrolled from the COMMUNITY SUPPORTS Waiver. Note: Children's PCA does not count as it is a state plan Medicaid service. Source: COMMUNITY SUPPORTS Waiver Manual
E2-95	Service needs outside the scope of Waiver Services are identified in IFSP/FSP and addressed	Review Service Notes, IFSP/FSP, and Family Training Summary Sheets to ensure that the EI has identified and addressed all service needs regardless of the funding source. Source: COMMUNITY SUPPORTS Waiver Manual
E2-96	Authorization forms are completed for services, as required, prior to service provision	Review the person's IFSP/FSP to ensure the Authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Early Interventionist's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS-enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. Source: COMMUNITY SUPPORTS Waiver Manual

E2-97	Service notes reflect monitorship within the first month of the start of an ongoing COMMUNITY SUPPORTS Waiver Service or provider change	Review Service Notes, IFSP/FSP, and service authorizations to determine if the individual began receiving a new ongoing service and/or the individual changed providers of a previously received ongoing service during the review period. If so, review Service Notes, IFSP/FSP, and Family Training Summary Sheets to determine if service or provider change was monitored within one month of the start date or provider change. Source: COMMUNITY SUPPORTS Waiver Manual
E2-98	Service Notes reflect monitorship within the second month from the start of an ongoing COMMUNITY SUPPORTS Waiver Service or provider change	Review Service Notes, IFSP/FSP, and service authorizations to determine if the individual began receiving a new ongoing service and/or the individual changed providers of a previously received ongoing service during the review period. If so, review Service Notes, IFSP/FSP, and Family Training Summary Sheets to determine if service or provider change was monitored within the second month after the start date or provider change. Source: COMMUNITY SUPPORTS Waiver Manual
E2-99	Service Notes reflect monitorship with the recipient within two weeks of a one-time service and reflect that the service was received	Review Service Notes, IFSP/FSP, Family Training Summary Sheets, and service authorizations to determine if the individual received any one-time services during the review period. If so, review the service notes to determine if the service was monitored to determine if the individual received the service. Source: COMMUNITY SUPPORTS Waiver Manual
E2-100	Service notes reflect on-site monitorship of Environmental Modifications within two weeks of completion	Review Service Notes, IFSP/FSP, Family Training Summary Sheets, and service authorizations to determine if an Environmental Modification was completed during the review period. If so, review Service Notes to determine if the modification was seen by the EI within two weeks of the completion date. Source: COMMUNITY SUPPORTS Waiver Manual
E2-101	Service notes reflect on-site monitorship of Private Vehicle Modifications within two weeks of completion	Review Service Notes, IFSP/FSP, Family Training Summary Sheets, and service authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review Service Notes to determine if the modification was seen by the EI within two weeks of the completion date. Source: COMMUNITY SUPPORTS Waiver Manual
E2-102	For any one-time Assistive Technology item costing over $2500.00, the EI has made an on-site visit to observe the item	Review Service Notes, IFSP/FSP, Family Training Summary Sheets, and service authorizations to determine if any Assistive Technology item costing over $2500.00 was provided during the review period. If so, review the Service Notes to determine if the item was seen in the recipient's possession by the EI. Source: COMMUNITY SUPPORTS Waiver Manual

E2-103	The Person/legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of COMMUNITY SUPPORTS Waiver Services with accompanying reconsideration / appeals information	Review Service Notes to determine if during the review period any Waiver Services were reduced, suspended, terminated, or denied. If this is noted, then review the Service Notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate reconsideration / appeals process. NOTE: If the person/legal guardian requests to terminate, suspend, or reduce the service, this Indicator is N/A. Source: COMMUNITY SUPPORTS Waiver Manual

E3	DDSN Only	Guidance
E3-01	Service Agreement signed and present in file	Review DDSN Service Agreement in file. Source: DDSN EI Manual Review DDSN Service Agreement in file.
E3-02	There is a Service Justification form in the file for any child 5 years of age or older being served in Early Intervention	Review the service notes and the service justification form to ensure that approval has been granted by the Office of Children's Services for the child to remain in Early Intervention. Source: DDSN EI Manual
E3-03	Transition to other services or settings is coordinated	Review FSP, Family Training Summary Sheets and/or Service Notes to ensure that the Early Interventionist completed, or is the process of completing, any task(s) they were assigned to follow-up on during transitions. Examples of these transitions could include hospital to home, BabyNet to school, home to childcare, etc. Source: DDSN EI Manual, EI Services Provider Manual
E3-04	For children who are seeking DDSN eligibility, and family training is identified as a need, the Early Interventionist has 45 days from the eligibility date to complete the FSP	Review Service Notes and FSP for documentation of the completed Plan. Source: DDSN EI Manual
E3-05 R	**Family Service Plan (FSP) is completed annually**	**FSP must be current within one year. The last page must be signed by the family and the EI.** **Source: DDSN EI Manual, EI Services Provider Manual**
E3-06	The Parent/ Caregiver was provided a copy of the Plan	Review service notes to verify that the parent/ caregiver was provided a copy of the Plan. Source: BabyNet Manual, DDSN EI Manual, EI Services Provider Manual
E3-07	FSP six-month review was completed by the end of the sixth month following the FSP	Ensure the FSP six-month review was completed by the end of the sixth month following the FSP. Source: DDSN EI Manual
E3-08	The Choice of Early Intervention Provider is offered annually	Review service notes, Family Training Summary Sheets, and the Acknowledgment of SC/EI Choice Form to ensure the family has been given a choice of providers and the choice is documented. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 6, & 9
E3-09	When file is transferred from another SC/Family Training provider a new FSP is completed or the current plan is updated within 14 days	Applies only to files transferred to new providers. Source: DDSN EI Manual

E3-10	FSP includes current information relating to vision, hearing, medical, therapy, and all areas of development to include health	Review sections 6a, 6b (6c if applicable) of the FSP to ensure information is current and includes therapy and developmental information. Source: DDSN EI Manual
E3-11	Goals are based on identified needs and the team's concerns relating to the child's development	Compare FSP sections 6a, 6b (6c if applicable) to the pages to determine if the Plan indicates who should do what and where it will take place. There should only be one goal per page. Source: DDSN EI Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 6, 8, & 9
E3-12	Goals are/have been addressed by the Early Interventionist	Review Service Notes and Family Training summary sheets to determine if all goals have been or are being addressed by the EI. All developmental goals should be addressed within 3 months of that goal being identified as a need. If the goal(s) are not being addressed, review documentation for supporting information noting why they haven't been addressed. Source: DDSN EI Manual, EI Services Provider Manual
E3-13	Goals are adjusted, terminated or added based on ongoing assessment, lack of progress, or parent/professional request	Review goal pages of the FSP to ensure that all goals are terminated, adjusted or added based on ongoing assessment, lack of progress, or parent/professional request. Source: DDSN EI Manual, EI Services Provider Manual Supports CQL Shared Values Factor 8
E3-14	FSP “Other Services” reflects current services	The FSP “Other Services” worksheet must be in all EI files and must reflect current services (Waiver, Center based child care, OT, ST, PT, FT amount, frequency, and duration, Family Support Funds, Respite, ABC, etc). Changes in service delivery must be documented on the FSP. Source: DDSN EI Manual
E3-15	If the child's FSP indicates the need for more than 4 hours per month of Family Training, the service notes indicate that information has been sent to the Office of Children’s Services for approval	Review frequency of Family Training as identified on the FSP. If the frequency noted on the plan is more than 4 hours per month of Family Training there should be documentation indicating that the file was sent to the Office of Children's Services for approval. Source: DDSN EI Manual
E3-16	Assessments are completed every 6 months, or as often as changes warrant	Review assessment dates on chosen assessment tool(s) and FSP to ensure they are completed every 6 months, or as changes warrant (i.e., significant improvement or regression). Note: Applies to Assessments completed as of 1/1/10 Source: DDSN EI Manual, EI Services Provider Manual Supports CQL Shared Values Factor 8

E3-17 W	Family Training is provided according to the frequency determined by the team and as documented in the Other Services section of the FSP	The FSP should outline the frequency and duration of Family Training. Review the ISRs, Family Training summary sheets and/or FSP "Other Services" section to ensure that Family Training is provided at the frequency and duration outlined. If the frequency and duration outlined is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule. Source: DDSN EI Manual, EI Services Provider Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 8, & 9
E3-18	Family Training summary sheets include goals and objectives for each visit as well as follow-up objectives for the next visit	Family Training summary sheets should indicate the scheduled time and date of the next visit and what the caregiver will work on with the child until the next training visit. Review Family Training summary sheets to ensure that they include goals and objectives for each visit as well as objectives for the next visit with an error rate of no more than 2 mistakes during the review period. Source: DDSN EI Manual
E3-19	Family Training activities are appropriate for the child's developmental needs	Review EI assessment tool(s), therapy, provider reports and FSP and compare to Family Training summary sheets. Source: DDSN EI Manual Supports CQL Basic Assurances Factor 8, Shared Values Factor 3, 8, & 9
E3-20 W	Entries for Family Training visits include how family member(s)/ caregiver(s) participated in visit	Review Family Training summary sheets and Service Notes to ensure that family/caregiver participated in training sessions. To state that the parent/caregiver was present is NOT sufficient. The summary of visit should include how the parent/caregiver actively participated in the visit. Review Family Training summary sheets to ensure that they include this information. Source: DDSN EI Manual
E3-21	Family Training activities should vary	Review the Family Training summary sheets to ensure that the activities vary in order to meet the outcomes for the child. Source: DDSN EI Manual
E3-22	Family Training activities correspond to outcomes on the FSP goal pages	Review goals (section 10) and Family Training summary sheets. Compare goals with Family Training activities. Source: DDSN EI Manual. EI Services Provider Manual
E3-23	Time spent/reported preparing for a Family Training visit corresponds with the activity planned	Review Service Notes and Family Training Summary Sheets to determine if the time reported for preparing for a Family Training visit corresponds to the activities completed during the visit. For example, an EI should not report 15 minutes of "prep time" for a visit if when the EI got to the home they worked on singing songs or putting puzzles together. Source: DDSN EI Manual
E3-24	If less than 2 hours per month of Family Training is identified on the FSP there is an approved Service Justification Form in the file	Review the FSP Other services section to determine the frequency of Family Training. If the need for Family Training is less than 2 hours per month there must be a service justification form present and signed by the Supervisor. Source: DDSN EI Manual

E3-25	If the Early Interventionist is unable to provide Family Training for an extended period of time (more than a month) was the family offered a choice of an alternate Early Interventionist	Review the Service Justification Form, service notes, and/or Family Training Summary Sheets to ensure the family was offered an alternate Early Interventionist to provide Family Training. Source: DDSN EI Manual
E3-26	Entries are clear and are documented within 7 business days of services being rendered	Review Service Notes to ensure clarity and inclusion of name/initials of the Early Interventionist. All services must be documented in the file within seven business days of delivery. Source: DDSN EI Manual. EI Services Provider Manual
E3-27 W	All items in the record are maintained in chronological order in the respective sections	Review records from all program areas that the person is involved with to determine if documents located in the respective sections of the record are maintained in chronological order. Source: DDSN EI Manual. EI Services Provider Manual
E3-28 W	Service note entries reference the appropriate Family Training summary sheet	Review Service Notes to ensure dates match dates on Family Training summary sheets. Source: DDSN EI Manual. EI Services Provider Manual
E3-29	Service notes document why and how the Early Interventionist participated in meetings/appointments on the child's behalf	Review Service Notes to ensure why and how the Early Interventionist participated in the meeting/appointment. The Early Interventionist must justify why they are reporting the time that they are at the meeting/appointment. For example, it would not be appropriate for an EI to attend a Developmental Pediatrician's appointment and then report time for attending the entire appointment. Source: DDSN EI Manual
E3-30	ISRs are present and reflect services rendered correctly	Review ISRs, Service Notes and Family Training Summary Sheets to compare documentation with reporting on ISRs. Source: DDSN EI Manual. EI Services Provider Manual
E3-31	If applicable, documentation in service notes indicates that the case was closed	Review service notes of a closed file to determine if it was documented that the case was being closed.
E3-32 Not included in score	Did the child receive more than 2 hours of Service Coordination in any calendar month? (except for the months in which an initial plan, annual plan, or transition conference were held)	During the review period, except for the months in which an initial plan, annual plan, or transition conference were held, did the child receive more than 2 hours of Service Coordination in any calendar month? If so, document the month(s) and total amount of time for the month. For example: April 2011, 2:23; June 2011, 3:35. Note: For Informational purposes only. Does not affect the score.

E3	DDSN Only MR/RD Waiver	Guidance
E3-33	The content of the FSP clearly justifies the need for MR/RD Waiver services	Review the FSP to ensure that the MR/RD Waiver services being authorized are justified according to the MR/RD waiver service definitions. Source: MR/RD Waiver Manual
E3-34 R	**The FSP includes MR/RD Waiver service/s name/s, frequency of the service/s, amount of service/s, duration of service/s and valid provider type for service/s**	**For each Waiver service received by the participant, the FSP must document the need for the service, the correct waiver service name, the amount, frequency, duration and the provider type [refer to the MR/RD Waiver Document for provider types (Chapter 2 of MR Waiver Manual)].** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" or, "per week" or "weekly" as applicable).** **Note: Regarding "duration" check only that a duration is specified.** **Source: MR/RD Waiver Manual**
E3-35	The Freedom of Choice Form is present	Review the record of those enrolled or re-enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). Source: MR/RD Waiver Manual
E3-36 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Early Interventionists for all consumers except for those consumers whose eligibility determination is "time-limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these re-evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Note: Look only at timelines and who completed it.** **Source: MR/RD Waiver Manual**
E3-37	The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination	Review the most current LOC determination and compare it to information in assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment. Note: Look only at lines on LOC Assessment Source: MR/RD Waiver Manual

E3-38 R	**The Current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete with appropriate responses.** **Note: Ensure that all areas are complete or checked.** **Source: MR/RD Waiver Manual**
E3-39 W	Documentation is present verifying that a choice of provider was offered to the participant/legal guardian for each new MR/RD Waiver service	Review the Service Notes, FSP, and Family Training Summary Sheets to determine if the participant/legal guardian was given a choice of provider of service each time a new service was authorized. Source: MR/RD Waiver Manual
E3-40	Acknowledgment of Rights and Responsibilities (MR/RD Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by the participant/legal guardian, if applicable) on the current and previous forms to ensure they have been completed annually (within 12 months of the previous form). Source: MR/RD Waiver Manual
E3-41	MR/RD Waiver services are provided in accordance with the service definitions found in the waiver document	Review Service definitions in the MR/RD Waiver document (Chapter 2 of the MR/RD Manual) for each service that the participant is receiving. Review the participant's Plan, service notes and relevant service assessments to ensure that services are being provided according to the definitions. Source: MR/RD Waiver Manual
E3-42	MR/RD Waiver services are received at least every 30 calendar days	Review Services Notes, FSP, and Family Training Summary Sheets, to ensure that the participant has received or is receiving at least one Waiver service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 calendar days, the participant should have been disenrolled from the MR/RD Waiver. Note: Children's PCA and Private Duty Nursing do not count, as they are State Plan Medicaid Services. Source: MR/RD Waiver Manual
E3-43	Service needs outside the scope of Waiver services are identified in Plans and addressed	Review FSP, Service Notes, and Family Training Summary Sheets to ensure that EI has identified and addressed all service needs regardless of the funding source. Source: MR/RD Waiver Manual
E3-44	Authorization forms are properly completed for services, as required, prior to service provision	Review the participant's plan to ensure that authorization forms for services rendered are present and note a "start date" for services that should be the same or after the date of the EIs signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS-enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. Source: MR/RD Waiver Manual

E3-45	Service Notes reflect monitorship within the first month of the start of an ongoing MR/RD Waiver service or provider change	Review the FSP, Service Notes, and service authorizations to determine if the participant began receiving a new ongoing service and/or changed providers of a previously received ongoing service during the review period. If so, review service notes, the Plan and other documentation in the record to determine if the service was monitored within one month of the start date or provider change. Source: MR/RD Waiver Manual
E3-46	Service Notes reflect monitorship within the second month from the start of an ongoing MR/RD Waiver service or provider change	Review the FSP, Service Notes, and service authorizations to determine if the participant began receiving a new ongoing service and/or changed providers of a previously received ongoing service during the review period. If so, review service notes, the Plan and other documentation in the record to determine if the service was monitored within the second month of the start date or provider change. Source: MR/RD Waiver Manual
E3-47	Service Notes reflect Monitorship with the recipient/legal guardian (if applicable) within 2 weeks of a one-time service and reflect that the service was received	Review Service Notes, FSP, Family Training Summary Sheets and service authorizations to determine if the participant received any one-time services during the review period. If so, review the service notes to determine if the service was monitored within two weeks of receipt to determine if the individual received the service. Source: MR/RD Waiver Manual
E3-48	Service Notes reflect an on-site monitorship of Environmental Modifications within 2 weeks of completion	Review Service Notes, FSP, Family Training Summary Sheets and service authorizations to determine if an environmental modification was completed during the review period. If so, review the Service Notes to determine if the modification was seen by the EI within 2 weeks of the completion date. Source: MR/RD Waiver Manual
E3-49	Service Notes reflect an on-site monitorship of Private Vehicle Modifications within 2 weeks of completion	Review Service Notes, FSP, Family Training Summary Sheets and Service Authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the EI within 2 weeks of the completion date. Source: MR/RD Waiver Manual
E3-50	For any one-time Assistive Technology item costing over $2500.00, the Early Interventionist has made an on-site visit to observe the item	Review Service Notes, FSP, Family Training Summary Sheets and Service Authorizations to determine if any assistive technology item costing over $2500.00 was provided during the review period. If so, review the Service Notes to determine if the item was seen in the recipient's possession by the EI. Source: MR/RD Waiver Manual

E3-51	The Participant/Legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of MR/RD Waiver services with accompanying reconsideration/appeals information	Review Service Notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the participant/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate reconsideration/appeals information. *NOTE: If the participant/legal guardian (if applicable) requested to terminate, suspend, or reduce the service, this Indicator is N/A* Source: MR/RD Waiver Manual

E3	DDSN Only HASCI Waiver	Guidance
E3-52	The content of the FSP clearly justifies the need for Waiver services	Review the FSP to ensure that the Waiver services being authorized are justified in the content of the FSP. Source: HASCI Waiver Manual
E3-53 R	**The plan includes HASCI Waiver service/s name, frequency of the service/s, amount of service/s, duration of service/s and provider type for service/s**	**For each waiver service received by the person, the plan must document the need for the service; the correct waiver service name/ acceptable substitute as listed in the Waiver manual, the amount, frequency and duration of the service and the provider type (refer to the HASCI Waiver Document for provider types).** **Source: HASCI Waiver Manual**
E3-54	The Freedom of Choice Form is present	Review the record of those enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). NOTE: Look at only those enrolled, re-enrolled or who turned 18 during the review period. Source: HASCI Waiver Manual
E3-55	The Initial Level of Care is present	Review the initial LOC determination to determine if it was completed prior to or on the date of Waiver enrollment. For ICF/MR Level of care, the initial Level of Care date is the "effective date" on the Certification Letter (ICF/MR Level of Care). For NF Level of Care, the initial Level of Care date is the date on the CLTC transmittal form (NF Level of Care, HASCI Form 7). NOTE: A person must be enrolled in the Waiver within 30 days of the initial Level of Care (LOC) determination. NOTE: If the person is enrolled in the Waiver within 30 days of the initial LOC determination the LOC effective date is valid for 365 days from the initial LOC date. Source: HASCI Waiver Manual
E3-56 R	**The most current Recertification is dated within 365 days of the last recertification and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days and ensure all sections of the LOC Determination are complete. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Service Coordinators for all consumers except for those persons whose eligibility determination is "Time-Limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Source: HASCI Waiver Manual**

E3-57	The current Level of Care is supported by the current FSP and supporting assessments indicated on the LOC determination	Review the most current LOC determination (either a Nursing Facility Level of Care or an ICF/MR Level of Care is completed) and compare it to information in the current FSP and other assessments referenced as sources for the LOC evaluation to determine if documentation supports the current Level of Care assessment. If the ICF/MR Level of Care is completed, the supporting assessments used to make the determination will be listed on the ICF/MR LOC determination and summarized in the FSP. If the Nursing Facility Level of Care is completed, the results of the determination will be summarized in the FSP. Source: HASCI Waiver Manual
E3-58	On FSP documents where the person refused a Waiver service(s), the risks associated with refusing the service(s) were addressed	Review service notes and other record documentation along with all FSPs completed during the review period to determine if a person participating in the Waiver refused a HASCI Waiver service. If a service was refused, review the record to locate documentation that the risks associated with refusing the service were addressed. Source: HASCI Waiver Manual
E3-59	Records verify that evaluations/reevaluations were completed in accordance with procedures specified in the approved Waiver	For ICF/MR Level of Care, initial evaluations are requested from SCDDSN's Consumer Assessment Team. The EI must submit a packet of information to the team to determine LOC. Re-evaluations are completed by Early Interventionists for all consumers except for those persons whose eligibility determination is "time-limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these re-evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. For ICF/MR Level of Care Re-evaluations, the date the Level of Care Re-evaluation is completed, is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 and expiration date of 7/2/09.For NF Level of Care, Community Long Term Care (CLTC) conducts initial evaluations. The EI is responsible for obtaining consent from the potential Waiver participant and forwarding the consent and transmittal to CLTC. DDSN Early Intervention staff completes re-evaluations. For NF Level of Care re-evaluations, service notes must reflect that the reevaluation occurred on a home visit with the Waiver participant and the reevaluation was staffed with the Early Intervention Supervisor or other responsible party within 2 working days of the home visit as verified by initial and date of the supervisor on DHHS Form 1718. The staffing date is the NF LOC date. Source: HASCI Waiver Manual
E3-60	If the person was disenrolled/terminated from the Waiver, the Termination (HASCI Form 8) was completed within 2 working days of the disenrollment date	Review the service notes, the FSP and Termination form to ensure that the EI completed the form within 2 working days of notification that the Waiver participant needed to be disenrolled. Source: HASCI Waiver Manual
E3-61 W	Documentation is present verifying that a choice of providers was offered to the person/family for each Waiver service	Review the service notes and the person's Plan to determine if the person or guardian was given a choice of provider of service. Source: HASCI Waiver Manual

E3-62	The Acknowledgement of Choice and Appeal Rights is completed prior to Waiver enrollment and on an annual basis	Review the record to ensure that the Acknowledgement of Choice and Appeal Rights (HASCI Form 19) is present. Review signature dates on the forms to ensure they were completed prior to Waiver enrollment and on an annual basis Source: HASCI Waiver Manual
E3-63	The Acknowledgement of Rights and Responsibilities is present	Review the record to ensure that the Acknowledgement of Rights and Responsibilities (HASCI Form 20) is present. This must be completed "one-time" at the Plan meeting. For new Waiver participants it must be completed prior to Waiver enrollment. It is not required annually. Persons will not have this form on record prior to December 2004 Score "Met" in this case. Source: HASCI Waiver Manual
E3-64	Waiver services are provided according to provisions in the service definitions in the Waiver document	Review service definitions in the Waiver documents for each service that the person is receiving. Review the person's FSP and Service Notes to ensure that services are being provided according to the definitions. Source: HASCI Waiver Manual
E3-65	If Nursing Services are provided, an order from the physician is present and coordinates with the Authorization of Services Form (HASCI Form 12-D)	Review record to ensure that a doctor's order is available and is consistent with the amount and type of Nursing Services authorized for the person. Source: HASCI Waiver Manual
E3-66	HASCI Waiver services are received at least every 30 days	Review services notes, the IFSP, and IFSP Amendments to ensure that the person has received or is receiving at least one Waiver service each month during the review period. A service must be received during each calendar month. If at least one service was not received each month, the person should have been disenrolled from the Waiver. For example, if a Waiver participant receives a Waiver service on March 17th and receives no other Waiver services before April 30th, then the Waiver participant would be disenrolled from the Waiver. Source: HASCI Waiver Manual
E3-67	Service needs and personal goals outside the scope of Waiver services are identified in FSP documents and addressed	Review the FSP documents, service notes, and other documentation in the record to ensure that the EI has identified and addressed all service needs and personal goals for the person, regardless of the funding source. Source: HASCI Waiver Manual
E3-68	Authorization forms are completed for services, as required, prior to service provision	Authorization for services forms are present and note a "start date" for services that should be the same or after the date of the EI's signature. Authorization forms are required for all services except Prescribed Drugs. Source: HASCI Waiver Manual
E3-69 W	The established Waiver documentation index is followed	Review the Waiver information in the record and compare it to the established Waiver documentation index. Source: HASCI Waiver Manual

E3-70	Service Notes reflect Monitorship within 2 weeks of the start of an ongoing service or provider change and include the usefulness, effectiveness, frequency, duration and the person / family's satisfaction with the service	Review service notes, the FSP and service authorizations to determine if the person began receiving a new ongoing service and/or the person changed providers of a previously received ongoing service. If so, review Service Notes, the FSP and other documentation in the record to determine if service or provider change was monitored within 2 weeks and documentation regarding include the usefulness, effectiveness, frequency, duration and the person/family's satisfaction with the service is present. Source: HASCI Waiver Manual
E3-71	One-Time Services: Service Notes reflect contact with the person within 2 weeks of the service and reflect that the service was received	Review service notes, the FSP and service authorizations to determine if the person received any one-time services during the review period. If so, review the service notes to determine if the service was monitored within 2 weeks to determine if the person received the service and provides a statement of usefulness and effectiveness of the service and the person's/family's satisfaction with the service. Source: HASCI Waiver Manual
E3-72	Service Notes reflect an on-site visit for Environmental Modifications within 2 weeks of completion	Review service notes, the FSP and service authorizations to determine if an Environmental Modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the EI within 2 weeks of the completion date. Also review documentation to ensure support of the usefulness and effectiveness of the service along with the person's/family's satisfaction with the service. Source: HASCI Waiver Manual
E3-73	Service Notes reflect an on-site visit for Private Vehicle Modifications within 2 weeks of completion	Review service notes, the FSP and Service Authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review the service notes to determine if the modification was seen by the Early Interventionist within 2 weeks of the completion date and documentation is available to support the usefulness and effectiveness of the service along with the person's/family's satisfaction with the service. Source: HASCI Waiver Manual

E3-74	For any one-time service that costs $1500.00 or more, the Early Interventionist has made an on-site visit to observe the item and to document the item's usefulness and effectiveness	Review service notes, the FSP and Service Authorizations to determine if any one-time service costing over $1500.00 was provided during the review period. If so, review the service notes to determine if the item was monitored on-site by the EI and documentation is available to support the usefulness, effectiveness, and benefit of the service along with the person's/family's satisfaction with the service. Source: HASCI Waiver Manual
E3-75	Documentation is present verifying that a provider is being actively sought when a provider is unavailable for any Waiver Service	Review the service notes and the person's FSP to determine if the Early Interventionist is actively seeking a provider of a Waiver service when a provider has not been found to provide the service. Source: HASCI Waiver Manual.
E3-76	Nurse supervisory reports are present for attendant care services and the FSP includes the need, frequency and intensity of the supervision	Review the FSP to assure it includes the need for supervision or a statement that the person or responsible party is able to direct his/her care. Review the “Other Services” section of the FSP to assure that it includes the frequency and intensity and duration of the nurse supervision of attendant care services. Review nurse (LPN or RN licensed to practice in the state) supervisory progress reports. Nurse supervisory reports must be received and reviewed by the EI. Nurse supervisory reports are required from the nursing provider at least every 120 days unless there is a statement that the person or responsible party is able to direct his/her own care. Look for a copy of the nurse's license in the file or review contact notes documenting the license # of the nurse. NOTE: Nursing providers may complete supervisory reports every 90 days (depends on the provider), however, at least every 120 days is required. Source: HASCI Waiver Manual”
E3-77	Waiver Tracking System is consistent with records regarding services and the FSP includes and justifies the need for all HASCI Waiver services	Review the Waiver services listed in the FSP and FSP amendments and compare them with the services listed on the Waiver tracking system. Also review the service authorizations and Medicaid Paid Claims to ensure that all Wavier Services are included and supported in the person's FSP. Score "Met" if the services listed on the Waiver tracking system are consistent with the services in the FSP/FSP Amendments. Note that there may be services on the Waiver Tracking System that were provided and completed prior to completion of the current FSP; therefore, they will not be present. Source: HASCI Waiver Manual
E3-78	The Legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of Waiver services with accompanying appeals information	Review service notes to determine if during the review period any Waiver services were reduced, suspended, terminated, or denied. If this is noted, then review the service notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate appeals process. Source: HASCI Waiver Manual

E3	Community Supports Waiver	Guidance
E3-79	The content of the FSP clearly justifies the need for COMMUNITY SUPPORTS Waiver services	Review the FSP to ensure that the COMMUNITY SUPPORTS Waiver services being authorized are justified in the content of the FSP. Source: COMMUNITY SUPPORTS Waiver Manual
E3-80 R	**The FSP includes COMMUNITY SUPPORTS Waiver service/s name/s, frequency of the service/s, duration of service/s, amount of service/s, and valid provider type for service/s**	**For each Waiver service received by the person, the FSP must document the need for the service, the correct waiver service name, the amount, frequency, duration and the provider type (as listed in the COMMUNITY SUPPORTS Waiver document in the COMMUNITY SUPPORTS Waiver manual).** **The amount of a service that is authorized in units should be specified in units, not in hours or days. The frequency of a service must be expressed in a manner that is consistent with how the service is authorized (e.g. "per month" or "monthly" or, "per week" or "weekly" as applicable).** **Note: Regarding "duration" check only that a duration is specified.** **Source: COMMUNITY SUPPORTS Waiver Manual**
E3-81	The Freedom of Choice Form is present	Review the record of those enrolled or re-enrolled during the review period (this is not to include the "back-up" record) to ensure that Freedom of Choice Form is present in the record. The form must be checked to indicate choice of waiver services in the community over institutionalization, completed (properly filled out), and signed by the waiver participant or his/her legal guardian (if applicable). NOTE: Look at only those enrolled, re-enrolled during the review period. Source: COMMUNITY SUPPORTS Waiver Manual
E3-82 R	**The most current Level of Care Determination is dated within 365 days of the last Level of Care Determination and is completed by the appropriate entity**	**Review the most recent and previous Level of Care evaluations to ensure that recertification occurred within 365 days. Initial ICF/MR evaluations are requested from SCDDSN's Consumer Assessment Team. Re-evaluations are completed by Early Interventionist for all individuals except for those whose eligibility determination is "Time-limited", "At Risk" or "High Risk". The Consumer Assessment Team must complete these evaluations. If the re-evaluation was not completed by the Consumer Assessment Team, then the Level of Care is not valid. The date the Level of Care Re-evaluation is completed is the effective date. Therefore, if the Level of Care Re-evaluation was completed on July 3, 2008 the effective date would be 7/3/08 with an expiration date of 7/2/09.** **Note: Look only at timelines and who completed it.** **Source: COMMUNITY SUPPORTS Waiver Manual**

E3-83	The current Level of Care is supported by the assessments and documents indicated on the Level of Care determination	Review the most current LOC determination and compare it to information in assessments/documents referenced as sources for the Level of Care evaluation to determine if documentation supports the current Level of Care assessment. Note: Look only at lines on LOC assessment. Source: COMMUNITY SUPPORTS Waiver Manual
E3-84 R	**The current Level of Care is completed appropriately**	**Review the most current LOC determination to ensure all sections of the LOC Determination Form are complete.** **Note: Ensure that all areas are complete with appropriate responses.** **Source: COMMUNITY SUPPORTS Waiver Manual**
E3-85	Documentation is present verifying that a choice of providers was offered to the person / legal guardian for each new COMMUNITY SUPPORTS Waiver Service	Review the Service Notes, FSP, and Family Training Summary Sheets to determine if the person/legal guardian (if applicable) was given a choice of provider each time a new service was authorized. Source: COMMUNITY SUPPORTS Waiver Manual
E3-86	The Acknowledgement of Rights and Responsibilities (COMMUNITY SUPPORTS Form 2) is completed annually	Review the record to ensure that the Acknowledgement of Rights and Responsibilities is present. Review signature dates (signed by the person/legal guardian, if applicable) on the current and previous forms to ensure they have been completed annually (within 12 months of the previous form). Source: COMMUNITY SUPPORTS Waiver Manual
E3-87	COMMUNITY SUPPORTS Waiver Services are provided in accordance with the service definitions found in the waiver document	Review Service definitions in the COMMUNITY SUPPORTS Waiver document (chapter 2 of CS Waiver manual) for each service the person is receiving. Review FSP, Service Notes, and Family Training Summary Sheets to ensure that services are being provided according to the definitions. Source: COMMUNITY SUPPORTS Waiver Manual
E3-88	COMMUNITY SUPPORTS Waiver Services are received at least every 30 calendar days	Review Service Notes, FSP, and Family Training Summary Sheets to ensure that the person has received or is receiving at least one Waiver Service every 30 calendar days during the review period. A service must be received at least every 30 calendar days. If at least one service was not received every 30 days, the person should have been disenrolled from the COMMUNITY SUPPORTS Waiver. Note: Children's PCA does not count as it is a state plan Medicaid service. Source: COMMUNITY SUPPORTS Waiver Manual
E3-89	Service needs outside the scope of Waiver Services are identified in the FSP and addressed	Review Service Notes, FSP, and Family Training Summary Sheets to ensure that the EI has identified and addressed all service needs regardless of the funding source. Source: COMMUNITY SUPPORTS Waiver Manual

E3-90	Authorization forms are completed for services, as required, prior to service provision	Review the person's FSP to ensure the Authorization forms for services received are present and note a "start date" for services that is the same or after the date of the Early Interventionist's signature. Ensure that authorization forms are addressed to the appropriate entity (i.e., the DHHS-enrolled or contracted provider) and accurately indicate the entity to be billed (i.e., DHHS or the Financial Manager). Ensure that the amount and frequency are consistent with the plan. Source: COMMUNITY SUPPORTS Waiver Manual
E3-91	Service notes reflect monitorship within the first month of the start of an ongoing COMMUNITY SUPPORTS Waiver Service or provider change	Review Service Notes, FSP, and service authorizations to determine if the person began receiving a new ongoing service and/or the individual changed providers of a previously received ongoing service during the review period. If so, review Service Notes, FSP, and Family Training Summary Sheets to determine if service or provider change was monitored within one month of the start date or provider change. Source: COMMUNITY SUPPORTS Waiver Manual
E3-92	Service Notes reflect monitorship within the second month from the start of an ongoing COMMUNITY SUPPORTS Waiver Service or provider change	Review Service Notes, FSP, and service authorizations to determine if the person began receiving a new ongoing service and/or changed providers of a previously received ongoing service during the period in review. If so, review Service Notes, FSP, and Family Training Summary Sheets to determine if service or provider change was monitored within the second month after the start date or provider change. Source: COMMUNITY SUPPORTS Waiver Manual
E3-93	Service Notes reflect monitoring with the recipient within two weeks of a one-time service and reflect that the service was received	Review Service Notes, FSP, Family Training Summary Sheets, and service authorizations to determine if the individual received any one-time services during the review period. If so, review the service notes to determine if the service was monitored within 2 weeks of receipt of service to determine if the individual received the service. Source: COMMUNITY SUPPORTS Waiver Manual
E3-94	Service notes reflect on-site monitoring of Environmental Modifications within two weeks of completion	Review Service Notes, FSP, Family Training Summary Sheets, and service authorizations to determine if an Environmental Modification was completed during the review period. If so, review Service Notes to determine if the modification was seen by the EI within two weeks of the completion date. Source: COMMUNITY SUPPORTS Waiver Manual
E3-95	Service notes reflect on-site monitoring of Private Vehicle Modifications within two weeks of completion	Review Service Notes, FSP, Family Training Summary Sheets, and service authorizations to determine if a Private Vehicle Modification was completed during the review period. If so, review Service Notes to determine if the modification was seen by the EI within two weeks of the completion date. Source: COMMUNITY SUPPORTS Waiver Manual

E3-96	For any one-time Assistive Technology item costing over $2500.00, the EI has made an on-site visit to observe the item	Review Service Notes, FSP, Family Training Summary Sheets, and service authorizations to determine if any Assistive Technology item costing over $2500.00 was provided during the review period. If so, review the Service Notes to determine if the item was seen in the recipient's possession by the EI. Source: COMMUNITY SUPPORTS Waiver Manual
E3-97	The Person/legal Guardian was notified in writing regarding any denial, termination, reduction, or suspension of COMMUNITY SUPPORTS Waiver Services with accompanying reconsideration / appeals information	Review Service Notes to determine if during the review period any Waiver Services were reduced, suspended, terminated, or denied. If this is noted, then review the Service Notes to determine if the person/legal guardian was notified in writing regarding the denial, suspension, termination or reduction of the service and provided with the appropriate reconsideration / appeals process. NOTE: If the person/legal guardian requests to terminate, suspend, or reduce the service, this Indicator is N/A. Source: COMMUNITY SUPPORTS Waiver Manual